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ABSTRACT

A summary of proceedings of a conference on articulation by the American Dental Hygienists' Association is presented. Introductions to each paper are made by Cheryl Westphal. Papers are as follows: "Innovate or Rennovate?" (Connie Tussing); "Internal Forces Influencing Innovation" (Arch Lugenbeel); "Regional Linkage Programs" (Steven Jensen); "Statewide Interinstitutional Collaboration" (Mary Knight); "External Forces Influencing Innovation" (Brenta Davis); "Articulation: A Projective Model" (Barbara Nelson); "Cooperative Agreements: A Systems Approach" (Marcia Brand); "Recruitment Through Articulation" (Deborah Miller); "Recruitment Luncheon Address" (Elizabeth Pelton); "Summary and Conclusions" (Cheryl Westphal); Seven appendices are: appendix prologue; small group and facilitator roster; small group session I; small group session II; workshop evaluation; national representation; and participant roster. (SM)

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ARTICULATION: ALLIANCES FOR THE FUTURE SUMMARY OF PROCEEDINGS

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MARCH 4 - 6 1987

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ACKNOWLEDGEMENTS

On behalf of the American Dental Hygienists' Association, we are pleased to provide this summary of proceedings to those who are concerned with the future education and practice of dental hygiene professionals.

Articulation: Alliances for the Future was attended by leaders in the dental hygiene practice and educational community. It is our belief that the conference will be a landmark event in establishing efforts to share and develop resources. We are confident that these proceedings will be a valuable resource for those involved in planning for the future of the profession.

Appreciation is extended to the participants, presenters, and group leaders who gave so willingly of their expertise. The assembly shared information and expressed their views candidly, for which we are grateful.

These proceedings, like the conference itself, are presented with the hope that they will foster greater cooperation and understanding between practitioners and educators who are planning to meet societal needs today and tomorrow. If dental hygiene is to effectively fulfill its professional role, it will require the united efforts of all those involved in the preparation for and delivery of care.

WORKSHOP PLANNING COMMITTEE

Cheryl Westphal, Chairman, Fairleigh Dickinson University

Catherine Jensen, Southern Illinois University

Pauline Schmidt, Owens Technical College

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PROLOGUE

Participants in Workshop I expressed consensus on several major issues. They agreed that conditions of society are changing and those changes are dictating development of new approaches to health care delivery. They agreed that adaptability of health practitioners will be critical to the survival of individual "species," and therefore, knowledge based education and practice are essential. They agreed that not only must the nature of dental hygiene education change but the relationship of dental hygiene to other health disciplines must also change. They recognized that the educational preparation of practitioners cannot be confined to long established and narrowly defined standards of length and content, and that an insightful and innovative construction of a new education structure is needed. They identified six major roles of dental hygienists which relate to projections of the future, and would establish dental hygiene as an essential component of the nation's health resources. The consensus on issues discussed in Workshop I provided a philosophic framework for charting direction for the future.

During Workshop II, consensus on future roles and responsibilities of entry-level professional dental hygienists was developed. That consensus reflected participants' commitment to development of broader roles and increased practice options for dental hygienists. More importantly, it reflected affirmation of dental hygienists' commitment to promoting the health of all segments of society in ways which are consistent with societal conditions and needs. Finally, it reflected recognition that dental hygiene is an important health resource and is gaining recognition for its contributions to society.

The outcomes of Workshop I and II provided the background for deliberations of Workshop III. The goals for the third workshop were to identify the type and scope of curricula required to prepare entry-level professional graduates for changing roles and responsibilities; to identify educational system modifications which will be required to offer those curricula; and to develop strategies for effecting those modifications. Recommendations emanating from Workshop III were transmitted to the officers, Board of Trustees, and the House of Delegates of the American Dental Hygienists' Association.

In response to the recommendations developed by the dental hygiene community, the 1986 House of Delegates adopted policy relative to the future roles of the dental hygienist and the minimum entry level educational preparation required to support them. The policies follow:

Future Entry Level - Roles (13-86):

The American Dental Hygienists' Association affirms that the entry level dental hygienist of the future will be prepared to assume responsibilities in the roles of clinician, health promoter/educator, consumer advocate, administrator/manager, change agent and researcher in a variety of settings.

Future Minimum Entry Level (14-86):

The American Dental Hygienists' Association supports all aspects of formal dental hygiene education which includes certificate, associate, baccalaureate, and graduate degree programs; however, the American Dental Hygienists' Association declares its intent to establish the baccalaureate degree as the minimum entry level for dental hygiene practice in the future and to develop the theoretical base for dental hygiene practice.

It was then incumbent upon the Association to assist the dental hygiene education and practice communities as they worked toward developing a knowledge-based educational system that prepares health care providers who have the knowledge and skills needed to meet the current and future oral health care needs of the public.

The Education and Practice Workshop, Articulation: Alliances for the Future, was fourth in a series of workshops sponsored by ADHA. It was conducted to address the following goals:

1. To review information related to collaborative approaches in education.
2. To identify the benefits and barriers of articulation.
3. To determine the potential for implementing alliances in the dental hygiene educational process.

This workshop laid the foundation for the development of collaborative relationships between individuals, programs, and institutions. This effort was undertaken to support the development of a nationwide, knowledge-based dental hygiene educational system.



ARTICULATION: Alliances for the Future

Dental Hygiene Education & Practice Workshop

March 4-6, 1988
Hyatt Regency Chicago
Chicago, Illinois

PROGRAM AGENDA

WEDNESDAY MARCH 4, 1987

7:00 PM-8:30 PM Welcome Reception
Poster Session:
Innovations in
Articulation

THURSDAY MARCH 5, 1987

(9:00 AM-4:15 PM)

9:00 AM-10:25 AM

Welcome

Moderator:

Cheryl Westphal, RDH, MS

Opening Remarks

Connie Edstrom Tussing,
RDH, MBA,
ADHA President

Keynote Address:
Internal Forces
Influencing
Innovation

Arch Lugenbeel, PhD

10:25 AM-10:40 AM

Break

10:40 AM-11:45 AM

Regional Linkage
Programs

Steve Jensen, RT2(R), MS

11:45 AM-1:30 PM

Lunch (On your Own)

1:30 PM-2:40 PM

Statewide Inter-
institutional
Collaboration

Mary Knight, EdD

2:40 PM-4:15 PM

Small Group Session:
Benefits and Barriers
of Articulation

Workshop Participants

FRIDAY	MARCH 6, 1987	(8:00 AM-4:15 PM)	Moderator:
			Cheryl Westphal, RDH, MS
8:00 AM-9:05 AM	External Forces Influencing Innovation		Brenta Davis, EdD
9:05 AM-11:55 AM	Articulation: A Projective Model		Barbara Nelson, RDH, MS
9:55 AM-10:15 AM	Break		
10:15 AM-11:55 AM	Cooperative Agreements: A Systems Approach		Marcia Brand, RDH, MS
	Recruitment Through Articulation		Deborah Miller, RDH, MS
12:00 PM-1:30 PM	Luncheon for Sharing Recruitment Materials		Beth Pelton, RDH, MS
1:40 PM-3:00 PM	Small Group Session: Articulation as an Outcome		Workshop Participants
3:15 PM-4:15 PM	Summary/Conclusion (General Session)		Cheryl Westphal, RDH, MS

WELCOME
CHERYL WESTPHAL

Good morning. My name is Cheryl Westphal and I am the Past President of ADHA and the Chairman of the Planning Committee. On behalf of the American Dental Hygienists' Association, I would like to welcome you to our workshop, Articulation "Alliances for the Future". It is nice to welcome some returning members to ADHA Workshops and also to see some new faces.

Previous workshops were organized to provide a forum for communication between the education and practice communities. At those workshops, dental hygiene educators and practitioners began to chart the future of our profession based on demographic and environmental issues. It was the consensus of the participants that dental hygiene would become a knowledge based profession and that future practitioners require a broader educational base to meet the needs of a society in flux.

Future roles were identified and necessary skills and knowledge were initially addressed. This prompted a need to establish philosophical support for the professionalization of dental hygiene. In their collective judgment, the 1986 ADHA House of Delegates adopted policy reinforcing the need for baccalaureate educational preparation for future dental hygiene practitioners.

The proceedings from Workshop I, II, and III were disseminated to every constituent dental hygiene society and dental hygiene educational program.

This workshop is a result of requests from participants at previous workshops who are seeking mechanisms for preparing future dental hygiene practitioners to meet society's needs and our ever changing professional roles. We know that this is merely the first step in building collaborative efforts that must be embraced and fostered through time.

The goals of this workshop are to:

- A. Review information related to collaborative approaches in education.
- B. Identify the benefits and barriers of articulation.
- C. Determine the potential for implementing alliances in the dental hygiene educational process.

In an effort to achieve these goals, a variety of individuals with significant expertise will be presenting information. They will be addressing such issues as:

- Communication, collaboration and cooperation.
- Resource utilization.
- The process of articulation.
- The promise and problems of collaborative effort.

Each speaker will provide a 45 minute presentation. Fifteen minutes will be allowed for participant questions at the end of each presentation. Participants are asked to direct your questions to me as moderator by first giving your names and affiliation. Questions will then be referred to the presenter. At the completion of the presentations, you as participants, will break into small groups to address the issue before us.

Now I would like to introduce you to the committee who planned this workshop. Pauline Schmidt, Director of the Dental Hygiene Program at Owens Technical College; Catherine Jensen, Director of the Dental Hygiene Program at Southern Illinois University; and myself, Director of the Dental Hygiene Program at Farleigh Dickenson University. I would like to thank the Committee and ADHA staff for all their efforts in planning the workshop.

The Committee feels it is important for you to have a thorough understanding of ADHA's position on educational alliances and the role your professional association has assumed. To accomplish this I will call on Connie Edstrom Tussing, President of the American Dental Hygienists' Association. Not only does Connie have a professional commitment to this issue, but her personal commitment is of long standing. She has practiced clinical dental hygiene for 13 years and, in her capacity as an educator, has prepared dental hygiene practitioners for the past 7 years. Connie has an earned Masters of Business Administration from the University of Nebraska and strives to integrate her extensive background with our professional goals as we move into the future. It is my pleasure to present President Tussing.

OPENING REMARKS: INNOVATE OR RENNOVATE?
Connie Edstrom Tussing, RDH, MBA
ADHA President

TRENDS IN PRACTICE - CHANGES IN HEALTH CARE DELIVERY SYSTEMS

This nation is changing demographically. Economists state that America is becoming a two-tiered society where the middle class is shrinking as the gap between the affluent and poor widens. Scholars predict that if U.S. economic growth continues to be sluggish and unemployment increases, the trend toward greater inequality between classes may not reverse for many years.

The age characteristics of our population are also changing. We are witnessing a graying of America. By the year 2000, the over-65 age group will have grown by 40% and 45-64 age group by 50%. An anticipated baby boom in the 1990's will accompany this aging trend. This will likely result in a society that requires increased attention to the health care needs of the very young and the very old.

These trends must be considered as the profession of dental hygiene continues its growth. It is our responsibility to prepare practitioners to meet the needs of this changing society.

We are tasked with addressing these issues as we support an educational system that prepares practitioners to adapt to a society in flux. We are challenged by barriers and conflicts that arise both internally and externally. We must foster a strong commitment to creativity and innovation if we are to meet these challenges.

TRENDS IN HIGHER EDUCATION

In previous decades education has focused on the need for greater technology. Given the current demographic trend, it is clear that technical expertise alone will not be sufficient. Graduates of American colleges and universities must see themselves as able to shape the world in which they live. They must be more creative and flexible in order to adapt to our changing society.

Higher education is entering a period of questioning its purposes and quality. Powerful forces are reshaping American society and changing the demands placed upon higher education. The educational reform, which has previously focused on elementary and secondary schools has now moved to include colleges and universities.

The most critical demand is to restore higher education to its original purpose of preparing graduates for a life of involved and committed citizenship. Graduates must be able to solve complex problems and avoid simplistic solutions. They must have a profound understanding of what it means to be a citizen and be capable of helping this country retain leadership in a complicated world.

To move forward in a changing environment, it is essential to support the concept of liberal education. Liberal education provides a broad base of knowledge and requisite intellectual skills, develops an entrepreneurial spirit and a sense of civic responsibility.

HOW WILL THE PROFESSION OF DENTAL HYGIENE RESPOND?

RESPONSIBLE ADVENTURERS

How will the profession of dental hygiene respond to a changing environment? How will we prepare practitioners to adapt to the needs of this dynamic society? If we are to meet these challenges, our leaders must do more than grudgingly give ground to change. It is important to develop a sense of what we must change and what we must conserve. Change should be seen as an opportunity and a challenge. Change for the sake of change serves no purpose. The willingness to face change must be informed and reinforced. We must strive to be "informed, responsible adventurers." In doing so, we must be willing to create rather than accept, proact rather than react....Innovate Rather Than Renovate.

ADHA ROLE

As your professional association we strive to represent the collective needs of ADHA members and the profession as a whole. Professionals must take the lead in delineating career options for the public they represent and identifying ways of facilitating career advancement and change, never forgetting that the needs of society will be the driving force for such growth.

It is a fact that this nation is experiencing drastic changes within the health care delivery system. There is no doubt that the priorities, settings, personnel and utilization of service patterns of tomorrow will not be the same as today.

The American Dental Hygienists' Association believes that dental hygienists can make a difference in the nation's effort to increase access to health care at an affordable cost. Dental hygiene services are relevant to traditional health care, disease prevention, mental and social health and health promotion. They are also relevant to a variety of nontraditional settings such as rural clinics, hospices and HMO's.

Demographic trends suggest that dental hygiene services will continue to be relevant in both the traditional and nontraditional settings. Dental hygiene must assume a leadership role in the planning and management of preventive service in order to provide quality care cost effectively. Dental hygiene professionals will provide leadership by designing systems of health care delivery that facilitate access and continuity.

ADHA sees that dental hygienists can assume leadership in educating a new genre of professionals. Our profession's youth and flexibility afford both practitioners and educators the chance to be in the vanguard of change. Together, we can develop a work force that meets the needs of the future effectively and humanely.

Over the past few years ADHA has studied the existing educational system, been actively involved in practice issues and explored competence assurance concerns. We have conducted research, supported conferences and workshops, participated in issues at a national level and constantly sought input in our future planning activities.

Based on all of this information, the ADHA has adopted policy which continues to support all levels of formal dental hygiene education, yet recognizes the need for the development of an educational system that provides for a four year integrated curriculum. The outcome of this 4 year endeavor will be students that are prepared to function in future roles as dictated by the need of the public.

ADHA has been responsive to many forces with a variety of interest and concern. While we are planning professionalization activities, others are planning our "demise." Barriers and regression within the practice arena are posed to erode the very essence of our profession. Our successes and forward momentum have been viewed by some as threatening. However, the real threat is in not moving forward. Retrenchment and maintenance of the status quo would most assuredly prevent any evolution that is inherent in professional growth.

We have come together to plan for a productive, viable future. I ask you to consider the options.

EDUCATION OR TRAINING

GROWTH OR DETERIORATION

CHANGE OR EROSION

We have the ability and expertise within this group to make this workshop a landmark event for the profession and a model for others who are watching us very closely. What we accomplish today will impact upon tomorrow. Let us make tomorrow an event to look forward to and not a criticism of what could have been.

WORKSHOP INTRODUCTION

Cheryl Westphal, RDH, MS

Three individuals with significant expertise in the area of articulation will be speaking with you today. They were asked to address:

- communication, collaboration and cooperation
- resource utilization
- the process of articulation, and
- promise and problems of collaborative effort

The panelists are:

Arch Lugenbeel, PhD
Dean, Health Sciences Technology
Trident Technical College
South Carolina

Steve Jensen, MS
Director, Radiologic Technology
School of Technical Careers
Southern Illinois University

Mary Knight, EdD
Consultant
Department of Education
State of Florida

Each will provide a 45 minute presentation. Fifteen minutes will be allowed for participant questions at the end of each presentation. Participants will direct their questions to the moderator by first giving their names and affiliation. Questions will then be referred to the presenter. At the completion of the presentations the participants will break into small groups to address the issues before us.

INTRODUCTION: DR. ARCH LUGENBEEL, PHD

Cheryl Westphal, RDH, MS

As our profession continues to move into the future, we once again pause to reflect upon our journey. The route we have charted may be fraught with uncertainty, the path we walk, a test of our character. But as evidenced by our presence here today, we are committed to our destination and the belief that, if we do not keep walking, we will not arrive.

It is important to take the time to ponder, anticipate and dream about the future. The speakers assembled for this workshop will address issues pertinent to our discussion of articulation. In our efforts to innovate, we must prepare ourselves to reckon with the forces that will influence those efforts. Dr. Arch Lugenbeel, Dean of Health Sciences Technology at Trident Technical College in Charleston, South Carolina, has some thoughts on the internal forces influencing innovation. His experience with innovation and change qualifies him to address the issues before us.

Dr. Lugenbeel received a bachelor's of art in sociology from Duke University in North Carolina, a master's in education from the University of South Carolina, and a doctorate in education from Southern Illinois University at Carbondale.

His insight is derived from experience spanning a variety of environments. He has interacted with individuals as a counselor and faculty member, addressed the needs of the public and then served those needs through numerous government and institutional activities, and has served the educational system through his activities as an academic administrator.

It is with great pleasure that I invite him to share his insight on the internal forces influencing innovation. Dr. Lugenbeel...

KEYNOTE ADDRESS: INTERNAL FORCES INFLUENCING INNOVATION

Arch Lugenbeel, PhD
Dean, Health Sciences Technology
Trident Community College
Charleston, South Carolina

Many times it is the "little extras" that come into our daily working lives that mean the most. The "little extra" I bring to you today is defined by the role I have as your keynote speaker. A keynoter is one who keys or kicks off a meeting. That role is to inform, in a broad general way, to inspire and to challenge you. As the principals of your conference request, I am here to - "spark enthusiasm about articulation."

The little extras I intend to share with you relate to much of what you already know. The only difference is that I might deliver them in somewhat different fashion. Several words I will use throughout need to be understood. These are - innovation, collaboration, and articulation.

Innovation in its broadest sense means doing something different... seeing the old in a new way. There is nothing new under the sun, only different and better ways of organizing that which we already know.

In 1870, a bishop was visiting a small denominational college. He expressed to the president of the college that nothing new could be invented. The educator disagreed and said, "Why, in 50 years, I believe it may be possible to soar through the air like birds." The shocked bishop responded, "Flight is reserved strictly for the angels, and I beg you not to repeat your suggestion lest you be guilty of blasphemy!" That bishop was none other than Milton Wright, the father of Orville and Wilbur.

"Doing something different" meant experimentation and dogged-determination to Thomas Edison. Some saw no future in the electric light after his 5,000th failure. He viewed it as 5,000 ways closer to success. Innovators don't play it safe, they get involved, set their course and work together.

Collaboration, the second word, means working together for some purposeful undertaking. In this instance it is seeing the benefits in group interaction and consensus...the arriving at agreed upon activities and the sharing of end results.

Collaboration and cooperation are synonymous and will be used interchangeably. Dr. E. Boyer, Past U.S. Commissioner of Education, summarized the need for collaboration and cooperation as the urgent thing to do.

Due to people like Dr. Boyer at the national level, funding since WW II for education and health has stressed the development of regional compacts, cooperative arrangements, strengthening liaison efforts, linking schools and developing articulation models. Generally, the

grants related to the health field referred to collaboration between junior and senior institutions, college programs and medical centers, state and regional health educational programs and agencies, and health manpower producers and users. The tenor for cooperative activity has been set over time. It is not new. It is a powerful vehicle to get you where you want to go. By definition, it is purposeful.

In the book "The Future of Allied Health Education", the National Commission on Allied Health Education gives us examples of the importance of collaboration.

Besides the references to establishing federal grants to bring about collaborative efforts, it relates the promises and problems of getting things together. In capsule form, here are a few vignettes:

Promises

- * Collaboration holds great promise for attaining a variety of objectives (e.g., cost, quality, access, and continuity).
- * Movement toward genuine alliances begins with the educational programs and settings.
- * Accreditation and credentialing may promote the basis for collaborative arrangements.

Problems

- * Territorialism or turfdom cannot be resolved without professional commitment.
- * Collaboration requires commitment, resources, negotiation and compromise, and a willingness to subordinate one's specific interest to a larger objective.
- * Collaborative models cannot be transferred intact from one setting to another but must be tailored.

Articulation, the last of the words, is what this conference is all about. Defined, it closely resembles collaboration. Webster's defines it as "the action or manner of joining or interrelating."

Articulation--in this instance--is the process whereby institutions and/or associations agree to collaborate, formally or informally, and in turn hope to benefit by giving up some of their control to others in order to meet a common goal or goals.

Such arrangements of mutual concurrence benefit the student through continuity of learning, society by the elimination of duplication and waste of time and money, and can set the direction for you to accomplish present and future goals.

According to Elizabeth King and her cohorts from the Kentucky Allied Health Project, there are several things you can do to facilitate

articulation. The following were chosen, in abbreviated form, from their article, "Developing and Negotiating Transfer Agreements in Allied Health."

- * Accept the anxiety of the participants as a normal reaction to change. Be prepared for a few who actively or passively attempt to prevent the proposed change.
- * Don't allow opponents to use academic standards as a barrier. (Use the argument of shared curriculum development and standards maintenance.)
- * Accept the fact that conflicts will occur, there will be clashes of ideas, beliefs, attitudes, and values. Provide a supportive environment for this confrontation. Resolved differences will strengthen the group.
- * Be patient and expect small miracles. The process of change is slow, time is required.
- * Consciously maintain respect for each program's autonomy. Respect results in free and informed choice. Informed choice generally fosters commitment.
- * Establish diverse teams to facilitate agreements.

The health care system must respond to our changing society. We all know today is different than yesterday and tomorrow will be different still.

The internal forces impacting upon you as individuals and as ADHA members are basically those of expanding your knowledge base about articulation (what you are doing at this time) and recognizing the humanistic factors of resistance to change.

There are two statements in Modelnetics related to our humanistic side that are appropriate at this time:

The first is called the main event principle which states that unless things change, they remain the same (generally they tend to get worse).

The second is a statement of fact. It is as follows: People resist change! (a) Some people resist change and (b) people resist some change. Notice, not all people resist change--only some. Also, people resist some change. Would you resist a pay increase--a job promotion you felt you wanted and deserved? Of course not! To resist would be foolhardy.

Now, what about the human side of us that blocks our efforts--especially yours as dental hygienists. There are four barriers that need to be discussed at this juncture and these are: (a) territorialism (turfdom), (b) paternalistic relationships, (c) status perceptions and (d) security in the way things are.

Maslow, in his hierarchy of needs, stressed that security and status are second and third level needs. Until these are reasonably satisfied moving to the next level--that of "belonging"--is difficult. It is at the belonging level that collaboration/articulation comes about.

To articulate, territorialism and paternalistic attitudes need to be changed. Turfdom does not allow for open collaboration. Without collaborative effort you will have difficulty progressing.

Paternalistic attitudes between four-year and two-year institutions are a significant roadblock you must overcome. It must be recognized that each educational segment has its place in the sun. Each is striving in its own way to be the very best. Only through working together in meetings like this, can you recognize and appreciate the capabilities of each other and, in turn, eliminate elitist attitudes. The Kentucky project found elitism to be its biggest hurdle. All of you have a common heritage--dental hygiene. All of you share a common bond--society's dental health care. Use these as your foundation and move forward.

Each group, by its very nature, starts from its philosophic base and carves out its mission, goals and objectives. Collaboration starts with becoming aware of the other's philosophical and operational positions. Once this is accomplished, understanding the problem and concerns of the other group is facilitated. It is at this point that true collaborative efforts can begin - this is the action, the sharing, the period of resolve that lets down the drawbridge, that melts away turfdom and paternalistic attitudes. It also makes inroads into status perceptions, by recognizing that "we" are working together for a greater good, a better day. Remember, the sum of the parts, when properly working together, is truly greater than the whole.

Rather than eliminating one's personal security, collaborative effort tends to enhance it because it focuses on how best to solve the problem collectively. In turn, the shared effort defines one's role in more precise terms. It establishes the conditions and positions agreed upon through a mutual and beneficial arrangement.

The arrangement, as specified here, is one of articulation--the agreement between parties to affiliate and arrive at consensus on points of mutual benefit, that aid one another in meeting their respective goals/objectives in a more efficient manner than if they continued separately.

As I have stated, you must be willing to collaborate before you can actually articulate. What do you, as professionals need to become aware of to collaborate? Here are three places to start: (a) society oriented purposes, (b) institution oriented purposes and (c) student oriented purposes.

Societal needs for health care, especially dental health care, is continually growing. In our society today there are basically three groups--those who use dental care, those who do not, and those who want dental care and can't get it.

Those who use it are generally the middle income and above. Why? Because they are, in the main, more knowledgeable, more health conscious, and have the capacity to afford it.

The second group are those in our population who have never had, or do not understand the need for, adequate dental care. In most rural and inner-city areas of this country we can find young men and women in their 30s and older who have never had such care. Those below the poverty level, especially the school-age child, fits this criteria as well.

The third and last group are the homebound and the nursing home patients. How do they get their dental care? Who will deliver it? The graying of America will produce the fastest growing population segment in the very near future.

To meet these dental care needs, your collaborative efforts will be stretched to their capacity. You must be willing to meet with other individuals and groups and focus on society's needs. If you approach these task as hard negotiations, then you will lose ground quickly. Collaboration may take longer, but the end results will benefit society.

The same is true when you sit down as professional institutions. Collaboration benefits the goals and aims of all who "sup" at its table. I am sure the Kentucky educational system has improved for having their statewide project, as have other regional and state efforts. I know the southern Illinois area is better for the linkages we developed there.

The institutions gain through sharing. If you read the institutional mission statements, they basically say the same things. If we state them, why not work on them with collective effort? This would bring growth for both or all the institutions involved. The institutional faculty members would gain from sharing and solving program concerns. Their expertise and leadership would be recognized and enhanced. Students and the community at large will benefit through better quality programming and, in turn, better dental care. On the realistic side, institutional cooperation can and does aid recruitment in a declining applicant pool and where budget constraints limit offerings.

Students are the beneficiaries of programs that reduce repetition and have continuity in learning and overall better quality. It is anticipated that the student will be better educated, have potential for career growth, and a reasonable locus of control over their future because of your collaborative efforts.

The bottom line of articulation is to become efficient through shared goals, ideas, and services in order to facilitate the student's educational and career development.

Between educational institutions this means agreed upon activities such as:

*"No hassle" transfer of credit.

*Methods that facilitate nontraditional student entry and progress.

*Updating of those individuals in the practice setting or those who wish to retrain in order to come back into the work force.

*Ways to meet the cost and the time needed for advanced degrees.

Institutionally, we can accomplish these activities by sharing resources--ideas, faculty, facilities, and equipment. But what's more important is that through this sharing process we can develop a greater appreciation for one another and between our educational institutions.

The societal purpose, therefore, is to educate dental hygiene practitioners who can do their job with competence and who have the capability to respond to a changing society.

Let me leave you with this poem--a little extra that has helped me to look at life and take the next step forward.

Isn't it strange
That Princes and Kings
And Clowns that caper
In sawdust rings
And common people
Like you and me
Are builders for eternity.

Each is given a bag of tools,
A shapeless mass,
A book of rules,
And each must make
Ere life has flown
A stumbling block
Or a stepping stone.

I challenge you to look at the stepping stones of articulation, collaboration, and innovation to meet the needs of your professional future.

INTRODUCTION: STEVEN JENSEN, RT(R), MS

Cheryl Westphal, RDH, MS

As we continue to explore the future of dental hygiene education, we are fortunate to have with us a gentleman with considerable experience in the area of educational articulation. Steven Jensen is Director of Radiologic Technology with the School of Technical Careers for Southern Illinois University at Carbondale. He earned associate and bachelor degrees from the University of Nebraska Medical Center in Omaha, Nebraska, and a master's of higher education from Morehead State University in Kentucky. He has completed course work for a doctorate in vocational education administration at Southern Illinois University at Carbondale.

Through numerous papers and presentations he has addressed a variety of education and articulation issues including the articulation of dental auxiliary programs, the expansion of health occupations education, alternatives in allied health education, the linkage process, and the allied health articulation process.

His grant and research activities include participation on a 2 & 1/2 million dollar federal grant, funded to provide leadership in obtaining formal agreements of articulation in allied health fields in Kentucky, and an "Articulation and Linkage in Allied Health" grant to obtain formal agreements of articulation in allied health fields for central and southern Illinois.

Currently Mr. Jensen is working on several research projects, including the development of a statewide and/or nationwide allied health articulation concept, and a grant proposal for funding to develop a statewide approach to articulation in Illinois.

Now, to address the regional linkage process, it is my pleasure to introduce Mr. Steven Jensen.

REGIONAL LINKAGE PROGRAMS

Steven Jensen, RT(R), MS
Director, Radiologic Technology Program
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Carbondale, Illinois

You are going to read a plethora of definitions in these proceedings concerning the true meaning of the linkage process. Articulation, linkage, even cooperation to a certain point, are synonymous. Do not get bogged down with terminology. The key to this process is providing professional pathways for students which make sense, not just to you, personally, but make sense globally. Articulation, what is it? Very simply, articulation may be defined as the method or manner of jointing, such as bony joints in the human body. Linkages may be defined as a series or system of links, i.e. chain-like. Regional refers to a large and indefinite part of the surface of the earth, or district. How am I supposed to talk about regional articulation when we're talking about a large and indefinite part of the earth? To simplify things, I developed my own definition for regional educational linkages: a system of links between educational institutions in a previously defined district.

The first thing that comes to mind when we begin discussions about educational linkages is: How are we possibly going to do this? How are we possibly going to cut this monstrosity of a job into bite-size pieces. This is what you are beginning at this conference. This is what planning is all about. This is what getting involved with your organization is all about, and this is what my presentation is all about--A how-to-guide to the articulation/linkage process.

I. Historical Perspectives (North Carolina, Alabama, Florida, Kentucky, Illinois)

North Carolina, Alabama, Florida, and Kentucky are probably the major innovators in allied health articulation and linkages. Many other states have become more and more involved with linkages, but these were the pioneers. And when I say pioneers, I refer only as far back as the early to mid-1970s. Many have come before you, and what we learn through history is not to duplicate mistakes. The ADHA staff have almost all the literature developed in these particular states' attempts at allied health articulation and linkage.

Kentucky was the only state project to be federally funded. They received support to provide articulation and linkages between every institution with allied health curricula in the state. Formal agreements were developed which stated that certain courses would be transferred freely between these schools. Not just radiology, but Radiology 131 from School A and Radiology 123 from School B., etc. This was a very intense, demanding, and comprehensive project which took over three years to complete. Now, I am not going to say the Kentucky project worked beautifully. They still have some problems, but that is a matter of follow up, not a matter of development. The

major advantage that Kentucky had was that they had a statewide mandate. Funding was received by the Kentucky Department of Higher Education who said, "You folks will work together and become articulated together in this state." The problem with articulation is in keeping people working together. We cannot just get them together, we must keep them working together--forever. That can be a tremendous problem without the proper kind of support (mandate) from state or national offices.

Illinois was a different story. I was involved with this project from the very beginning. We were funded by the Department of Adult and Vocational Technical Education to produce a framework for articulation in the state. Our concept was to articulate not only between community colleges, and universities, but also to form agreements at the secondary school level. Why did we want to start with high school health occupation programs? We did this to get them started on anatomy, physiology, medical terminology, and career awareness of all of the allied health professions. After looking at 20 high school health occupation programs, we found that almost half of those taught an anatomy and physiology class that would rival what most of us are teaching. You would be very surprised at what is taught in these high school classes. Should these courses be freely transferable and accepted as college credits--in my opinion, yes! These classes not only meet or exceed some of the basic allied health college-level courses, but they also lead to ease in recruiting for those programs articulating with these high schools. Four-year institutions will be able to recruit from the two-year institutions that are providing education in your district and two-year institutions will be able to recruit from the high schools in your district. This is true articulation.

Recruitment is a logical end to true articulation. It has worked for us. We have worked out linkage agreements between Southern Illinois University and ten southern Illinois community colleges. Access is guaranteed to our health-related programs following one year of general education at the community college. What does that do for us? It gives us a student who has a better grasp of his/her career goals. It gives us a student who has a year of college under his/her belt. We lose fewer students to "first-year collegitis," and homesickness. Finally, we set up an unbeatable recruitment network. The problem with the Illinois project was that it was not mandated. It was a pilot project. Support for the project was extremely positive and the linkages I just explained are still in force even though funding has been lost. However, we cannot do it for free forever. We are losing some of our community college support. One of the best ideas for articulation, linkage, and recruitment that I have ever seen is losing ground due to lack of statewide mandate.

Remember something I said quite a while ago: "Articulation without mandate is like shipping bananas without a crate." I am not saying that linkages must be mandated in order for them to work. You, along with your professional organization, are building your own internal and cohesive mandate. You are to be commended for your attempt at consensus. For with consensus comes a power base, and with a power base comes direction and a swift closure of your articulation network.

II. The Impact of Regional Linkage

- A. Improved career mobility
- B. Increased inter-institutional cooperation
- C. Improved utilization of existing resources
- D. A clearer definition of entry-level and advanced-level competencies
- E. Decreased proliferation of programs

The impact of educational linkages beyond the need to meet professional requirements are first, improved career mobility. This was previously explained by the example of linking students from high school all the way to the university. Do not stop with the baccalaureate degree. We have a tendency to look only at our own professional courses as an end. Many students go on to obtain master's degrees and subsequent PhDs. We need to develop linkages from high school to PhD, not simply community colleges to baccalaureate. High school to PhD is true linkage.

How many times have you seen statements like these? "We realize you have completed two years of college work, but we can accept only one year. It will take you about three years to get a baccalaureate degree." "Your associate degree will not excuse you from completing the math and science courses which we require all entering freshmen to have." "We can't give you credit for all of your professionally oriented course work. Some of it is similar to our upper division work, and we can't give credit when the work was actually completed at the lower division." There are many schools in this country who respond to our students in this manner. How many of these students are going to be thrilled about working toward advanced degrees at these institutions? Where must they go to receive credit for their earned degrees--the next state? Think of the costs to that student trying to go across state lines--increased tuition, increased travel distance, and so on, and so on.

The second advantage to the linkage process is increased interinstitutional cooperation. If you get to know the people at the institution, it no longer remains an institution. You will be amazed at what can be done for students and for your own benefit, such as educational seminars, transfers, etc., when you just start talking to one person and make a friend at another school.

Improved utilization of existing resources is the third benefit to linkages. Why should six schools within a very small geographic region (district) teach exactly the same thing? Can we think of a better way without closing programs? It is amazing what people do when they begin to think about options. Will two plus two programming work? One plus two plus one? One plus three? etc., etc. Can university courses be taught at the community college and vice versa? Can faculty hold dual appointments? Keep your options open and work toward a common goal--a quality education for our students with a limited amount of wasted time and money.

The final advantage to linkage is a decreased proliferation of programs. I am not saying elimination of programs, I am saying decreased proliferation of programs. I have spoken to three different people in the last two days who told me their states had placed a moratorium on new programs of any kind. Within a month, due primarily to political pressure and no plan of organization for education, things happened which were rather destructive. New programs sprang up literally in the backyard of others--to the detriment of both. Quality linkage and articulation arrangements will alleviate these problems.

III. Barriers to The Linking Process

1. Interpersonal non communication
2. Avoidance of change
3. Conflicting state licensure laws
4. In-state vs. out-state tuition
5. Community college service districts

Barrier #1: Interpersonal non communication.

The most difficult barrier to overcome is the lack of interpersonal communication between program faculty and administration. This is normally due to the "somebody's out to get me" syndrome. "Why are they asking me?" "What do they want?" "If I give them this information, what will they do with it?" This syndrome is present in all of us to some degree. The way to cure this malady is to keep yourselves informed. Keep in contact with your national and state professional societies. Attend all of your district dental hygiene faculty meetings. Get at least one other person involved in these meetings. Actively seek out and speak to your state and national legislators. Do not allow yourself to become the weak link in the chain of communication. Information is the key to articulation and you are the gatekeepers. Do not lock that gate!

Barrier #2: Avoidance of change.

The change process will be addressed later in this paper. The key to change is understanding that it is normal for all people to resist it. Some of us accept change more readily than others. However, with time, patience and information, almost any change may be accepted by all.

Barrier #3: Conflicting state licensure laws.

This problem does not seem to create as much conflict in the dental hygiene profession as it does in other health-related occupations. Be aware, however, that some states require more extensive skills of their hygienists than others. This will have an effect on the number and type of credit hours which are freely transferable between institutions from different states.

Barrier #4: In-state vs. out-of-state tuition.

At Southern Illinois University, we draw students from Kentucky, Missouri, Tennessee, Indiana, and approximately 20 percent of our students are from Chicago institutions--300 miles away, but in the same state. Now, if I form articulation agreements with all of those across

state lines, and say, "Send your students over here to our university for our super-improved baccalaureate degree program!" what will stand in the way? The students from out-of-state may have been paying only \$50 per semester at their hometown community college. They may have been paying only \$500 a semester to attend the local university. If they cross our Illinois state line and attend our university, they will pay \$1,850 per semester, and that does not cover room, board, or books. Will this deter your out-of-state student applicants? You'd better believe it will! In your discussions concerning linkages, consider in-state tuition waivers for out-of-state students who are within your service area.

Barrier #5: Community college service districts.

Many state community/junior college systems penalize students who attend programs at community colleges away from the student's home district. Much higher tuition rates, loss of credits, etc., are examples of these penalties. A student wishing to attend dental hygiene courses may be forced to go out of the district in order to find this curriculum. Should the student be charged out-of-district tuition? No! If a student must transfer from one community college to another in the same state, should they lose credits or pay higher tuition? No!

The five barriers to the linking process should give you food for thought in your articulation efforts. You will find many others--keep communicating!

IV. Formal vs. Informal Linkage Agreements

Please do not think that you must go out there and push for formal linkage agreements. Your administrators will not accept the concept of formal agreements immediately. Remember those people who are in leadership positions at your schools. Do they really have a great love for the university down the road? Do they get along beautifully with all the community colleges within a 50 mile radius? Do they freely accept credits from the proprietary schools in the city next door? Most of them don't.

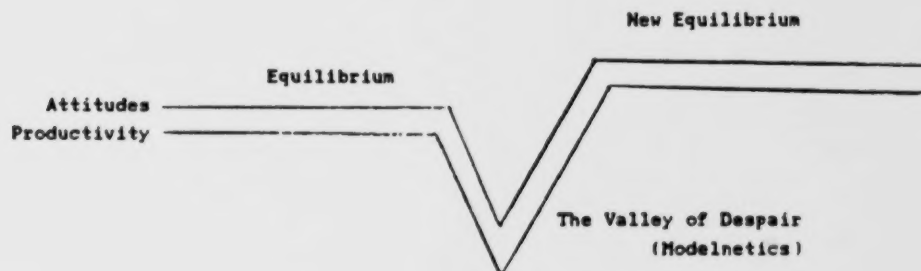
Most administrators are very protective of their schools. Why? Because these schools are funded by the state depending on the number of heads attending that school. Never forget this fact. Keep your administrators apprised of each step completed in the linking process. You must demonstrate to them that you will gain students through this process--not lose them. Formal agreements written too soon, without full support from all concerned, can lead to the death of your articulation efforts. Formal agreements are not a must.

Through my experience, informal agreements work extremely well. Educators are very honest and sincere people who make commitments hesitantly. However, once committed, they will stick things out to the end. Informal agreements, once decided upon, can be as binding and long-lasting as formal agreements. In the past, we have functioned almost exclusively with nonformal linkage agreements. The only problem

with these agreements come when one or more of the linkage participants leaves their institution. If they have not fully informed all of their faculty of the agreement and its stipulations, your linkage with that institution will fail. Keep all of your faculty up to date concerning the linkage process . . . especially when dealing with informal agreements.

V. The Change Process

FIGURE 1



The diagram above is a graphic representation of what we all go through when a "change" is forced into our lives. Let us look at dental hygiene education and the process you must endure over the next few years. At the left of the diagram is your present state--equilibrium. Your present attitudes and productivity as educators are indicated here. However, you have seen the future and have deemed that major curricular changes are necessary to meet the future needs (new equilibrium) of your students in the job market.

The forced change leads us all into the so-called "Valley of Despair" where attitudes and productivity are significantly lowered. Statements such as: "What are we going to do now?" "How can we ever reach that goal?" and "They can't make me do that!" are often heard in the Valley of Despair. It is your responsibility as a change manager to minimize the depth of the Valley of Despair. How do you do it? **Keep people informed!** Take the information you learned at this conference back to your faculty at other institutions, administrators, and the general public about the projected future of dental hygiene education. You must speak toward what the future will be, not what the future might be. Remember, your goal is to reach a new equilibrium as efficiently as possible. This can only be accomplished through minimizing the depth of the Valley.

I wish you all the best in this endeavor.

INTRODUCTION: MARY KNIGHT, EDD

Cheryl Westphal, RDH, MS

During the "Steps to the Future Workshop" we were encouraged to "take charge and shape our future." An endeavor of this magnitude has many fronts, and certainly one of them is legislative. The development of an effective lobbying strategy requires an understanding of the power and politics within a legislative body.

The merging of a health background with extensive lobbying experience makes Dr. Mary Knight uniquely qualified to comment on the legislative experience as it pertains to allied health education. A medical technologist, she worked as practitioner, administrator and teacher in that field for 12 years. Receiving a bachelor's degree in chemistry and drama from La Grange College, Dr. Knight holds a master's degree in vocational education and a doctorate in education from Florida State University. Her dissertation, entitled: A Study of Vocational Curriculum Articulation Practices in Florida Based on Two Case Studies, identified factors affecting the coordination of curriculum articulation between and among educational institutions.

Dr. Knight has consulted with the American College Testing Program on the implications of curriculum articulation in nursing. She also acts as a consultant to a consortium of 12 institutions in northwest Florida in curriculum articulation for nursing programs. She has assisted in developing educational funding guidelines and grant proposals.

For the last seven years Dr. Knight has acted as a Florida Department of Education consultant to health and public service programs where she works in such diverse areas as planning, funding, inservice training, process review, and curriculum development.

In addition to her numerous professional activities, Dr. Knight has conducted legislative and policy research, and has lobbied in both houses of the U.S. Congress and the Florida legislature. The American Vocational Association and Common Cause are but two of the organizations for which she has lobbied. Having served on the Florida state board of Common Cause for five years, she is presently the vice-chair of that organization.

At this time, it is my great pleasure to introduce Dr. Mary Knight.

STATEWIDE INTERINSTITUTIONAL COLLABORATION

Mary Knight, EdD
Program Specialist, Division of Vocational Education
Florida Department of Education
Tallahassee, Florida

I'm particularly pleased to be here because I have a close association with dental hygiene programs in Florida and have a great admiration for the educators and practitioners in the field.

I'll make one statement--only one--which I believe you will all agree with and that is probably the most important thing a speaker does is to sit down and shut up. Garrison Keillor said that when he stands before an audience, he's terrified until they respond to him. Then he relaxes, as any shy person should. When they laugh at a joke--he just wants to stay all day and tell them everything he knows. I promise not to do that. I plan to leave time for questions and comments because I believe that the most important thing gained from a workshop is the interchange between participants.

First, I plan to touch on some of the trends we're seeing in education today and some specific changes we're seeing in Florida. I will concentrate on what is and how to develop power and a specific use of power in the lobbying process.

Education in America is in a philosophical dilemma. A usually apathetic public is getting involved. They insist upon a better product and seem to be willing to pay the price for it. Industry is making new demands and are talking about reinstituting on-the-job training which could be devastating to the health field. The egalitarian philosophy of the past is giving way to a rise of elitism. Some dissatisfied consumers encourage us to shift to a centralized Japanese-like educational system. In Japan examinations are the centerpiece of education and passing exams determines which university students enter, in turn which occupation they pursue and consequently their status throughout adult life. On the other hand, locally controlled American education has evolved to serve a much different heterogeneous multicultural society and has attempted to educate all citizens to their fullest capacity. Careful consideration must be given to the implication of modeling the Japanese. This could drastically limit the opportunity for self-fulfillment and individuality of our citizens. We're already seeing changes ranging from a decrease in remediation, to increased testing. Several states are looking to standardization as a means of quality assurance. There is no question but that more radical changes will follow.

Florida is moving toward program articulation and has a statewide common course numbering system. Already many academic courses at a community college or university are deemed equivalent credit-wise and are transferable to any other state-operated university and community college. Local policy still controls exact course content so that two courses with the same number may not actually be the same. Florida has

a statewide articulation coordinating committee which encourages articulation between program levels. The associate degree must be fully accepted when transferred to a state-supported university. Local articulation agreements have been required between community colleges and universities since 1971, and have had varying degrees of success.

The Florida legislature has mandated that all occupational programs be assigned a level of either degree or certificate at the lowest level possible commensurate with sound professional practice. Probably dental hygiene will be classified as an associate degree and dental assisting as a certificate program. This is an attempt to curb degree inflation because some community colleges are giving nontransferable local degrees.

Florida has traditionally left operational education decisions at the local level and defense of local "turf" has prevented articulation in some cases. It could be that the new standardization will improve articulation between programs--now a somewhat elusive goal. Politically Florida is very much a "good ole boy" state and the legislature is noted for backing down under pressure. This time around may be different. Since 1983, we have had a new force behind educational reform called the Post Secondary Education Planning Commission (familiarily called Pep-C), a lay body appointed by the governor with no particular turf to defend and most importantly a great amount of rapport with the state legislature. This board with its six staff members is making unprecedented impact on education in our state. The group is so powerful that "good ole boy" politics doesn't work there. That is not to imply that their decisions are above reproach, only that they don't need to listen to outsiders - and the legislature tends to follow Pep-C's lead.

For example, last year the Pep-C commission published an allied health report in which they said there should not be a link between licensure and national accreditation. In other words, a candidate for licensure in the state of Florida should not be required to graduate from an accredited program. This recommendation was prompted by physical therapy's attempt to establish entry into practice at the master's level.

Because physical therapy backed down before our legislature met, Pep-C never actually developed legislation along these lines. Had they done so, we would have seen an interesting legislative session.

This issue of national accreditation could bring together medicine, dentistry, and all of allied health. I suggest that you find out if there is a Pep-C-like group in your state. They may not be as visible as you would expect. Find out where the power lies.

What is power? How do we get it? Does it corrupt?

Ancient philosophers defined power as "being." Emily Dickenson wrote:

To be alive is power,
Existing in itself,
Without further function,
Omnipotence enough.

Power is the ability to cause or prevent change. It has two dimensions - actual, the power held by the American Medical Association and American Dental Association, groups with big dollars and prestige; and potential power, the power held by emerging health professions. Nursing had little or no actual power 20 years ago, but had a large constituency with credibility. They are now a force to be reckoned with.

I've been told that Florida Dental Association members agreed to and are boycotting two companies which produced educational materials featuring dental hygienists. This mean-spirited act says that you are becoming a force to be reckoned with.

Lord Acton, a nineteenth-century historian, said: "Power tends to corrupt, and absolute power corrupts absolutely." This implies that force is the lowest common denominator of power. For this reason, power has been scorned and disparaged as a "dirty word". But if we eschew power, does it dissipate? No, another group or person fills the vacuum. If we accept this premise, the acquisition of power becomes expedient and perhaps not quite as intimidating.

Too often we imagine power as something we're born into or must buy with formidable amounts of money. Money is not the only commodity of exchange in the power game.

There are many ways of exerting power. We use nutrient power over a child for his/her safety. Women have been the recipients of nutrient power. As allied health workers we have been nourished, protected, excused from responsibility, and controlled. We are, to a point, what we are because of the many years of protection from the macho world. Now that we've broken the barrier, we have decisions to make. Do we participate in exploitive power, the most destructive form, the stuff of violence and war? Several years ago the press reported that a lobbyist for a large food chain in Florida called across the capitol rotunda to the President of the Senate, "Hey Dog Boy--come 'ere." The Senate President dutifully trotted over. The lobbyist announced to an assembly of onlookers, "Dog Boy's a good boy, he just ain't too bright." That's corrupted power.

Despite the glorification of wealth, there's a centrist spirit in America that is suspicious of big money. Observe the last national election--the big spenders didn't always win. Perhaps we should use our femininity to temper that world. Women are naturals in a display of integrative power, the forte of Gandhi and Martin Luther King. We have an instinct for defending the disaffected, the underdog. Integrative power is built on cooperation and coalitions between otherwise ineffective groups. Gandhi disarmed his opponents through

nonviolence and brought psychological and spiritual power to bear on the British Empire. What more natural coalition than between dental hygienists and the elderly, who often receive substandard, if any, dental health care at inflated prices?

But power used in the world of politics is competitive power--a negative process by which one person or group goes up because his/her opponent goes down. This power seeks an optimum level and the balance is ever changing. It can give zest and vitality to human relations. To have someone against you, at least means they are not over or under you. For example, accepting the rivalry of a dental association may even bring out dormant capabilities among you and assist you to move from potential to actual power.

There is no denying that moving from potential to actual power is difficult without considerable financial backing. But there are other important resources. You have visibility, not shared by all health professionals. Everyone knows dental hygienists and understands the services they offer. This gives you prestige, status, and in turn, credibility. You perform public relations every time you greet a patient, every time a dental supply house pictures a hygienist in an ad. Get on talk shows and discuss fluoridation and the need for the pursuit of regular preventive oral health care in schools or nursing homes. Push prophylaxis and the hygienist's role in patient education and preventive oral health care.

Many years ago when I was unbelievably naive, I equated lobbyists with influence peddlers who paid public officials for votes. I've learned that this may or may not be true and that there is more than one type of lobbyist. Any time we approach an elected official with the intent of influencing his/her votes, we're lobbying.

The most visible and notorious lobbyist represents special interests; for example, the tobacco lobbyist who tries to discount the scientific evidence that smoking is a health hazard. In this context special interest means that the issues in question are advantageous to certain persons or groups and more than likely detrimental to others.

At the other end of the continuum lies the public interest lobbyist like Ralph Nader or Common Cause. Their goal is to protect the citizenry from the unscrupulous manipulation of government by special interests. Common Cause was organized in 1970 by John Gardner, former Secretary of Health, Education and Welfare. He placed a full-page ad in the New York Times with a headline reading "Everybody's Represented But the People." This was during the last days of the Viet Nam war when the public was disillusioned and Congress seemed paralyzed. Within six months Common Cause had 100,000 members and a nationwide telephone network lobbying Congress. Common Cause now claims 250,000 members and is involved in process issues like government in the sunshine, campaign finance, protection of the Constitution, and more recently, military spending.

I learned to lobby as a volunteer for Common Cause. We public-interest lobbyists are guilty of a bit of piety. We don't buy dinners or support political campaigns in the name of the organization. I really enjoy the respect I receive as a Common Cause lobbyist. So I have to tell you a related story. I accompanied a group of health professionals to visit a legislator concerning the sunset of their practice act. This "good ole boy" began by telling us "girls," as he called us, about when the cosmetologists came to town to defend their licensure law.

He said, "You know there are some good lookin' women in that group. So we let 'em wine and dine us and had a good ole time. Then we said y'all go on home, we're not going to monkey with your licensure law."

I must admit that my feminist instincts were outraged. But one member of the group called his bluff. She offered to drive him to the public hearing and to buy his dinner. His face turned bright red but he took her up on it and she ended up with some valuable information. I must admit that she was, at that moment, a more level-headed lobbyist than I.

Few lobbyists fit clearly into the special interest or public interest mold. Professional organizations may lobby for special interests but often lobby economic issues which can lie between the two. For example, if your group cooperates with the American Association of Retired Persons (AARP) and the Gray Panthers in lobbying for less supervision of dental hygienists in nursing homes, this could be a public interest issue if dental health care costs are cut and accessibility to dental health care is increased. Educational reform which leads to time and money saved for students and government is a public interest issue. Direct billing of dental hygienists in private practice by insurance companies could be advantageous to the public if it saved costs. On the other hand, if you lobby an issue which strictly increases your monetary gain without also benefitting the public at large, this would be classified as a special interest issue.

Before beginning to lobby your legislature, select an experienced volunteer or professional lobbyist, who is knowledgeable of your issues, to be coordinator and full-time lobbyist during the legislative session.

Send out a questionnaire to members asking them to volunteer as lobbyists to particular legislators or as participants in a telephone tree. Someone needs to take charge of organizing a statewide telephone tree which can generate telephone calls and letters to each legislator. Telephone tree messages need to be clear and concise so that members are told exactly which bill is in question, its number and how you are asking the legislator to vote. Update a telephone tree often because one weak link can cause the process to fail. Don't use the telephone tree too often--volunteers are easily bored.

Update members in your newsletter and print some sample letters to legislators. Train a corps of lobbyists, preferably who live near the capitol, on the legislative process. Learn how a bill is processed from the time it is introduced until it is signed into law. Learn

which bills are assigned to which committees. Get to know the committee members and staff. Offer them the names of experts who can give testimony or other assistance. They work under pressure and sometimes write legislation on subjects foreign to them and their staff. Get to know both the committee staff and the legislator's own staff. These people have immense influence.

What are the rules of each chamber? Can a bill die in committee? Can they be sent to a "graveyard" committee? Can a bill be forced out of committee?

How soon are public hearings after the bills are assigned to committees? Learn how to request public hearings and what your rights are to do so. The public hearing is an excellent forum for getting your issues to the press and consequently to the public. Assign persons to prepare testimony for these hearings. Do thorough research and be sure all information is accurate. Choose articulate, well-informed people to present testimony. They may be asked questions after reading a statement. The written testimony should be handed to the hearing officer so that you're assured your points will appear in the proceedings. It can be very effective to have consumers and persons usually identified with the opposition to testify on your behalf. For example, if you are asking for the right to administer anesthesia, an anesthesiologist or anesthetist could give very effective testimony. A nursing home administrator or family member of a patient could give important testimony as to the atrocious state of dental health among nursing home residents, and thereby reinforce the need for dental hygienists to be allowed to practice there without undue restriction.

Legislative committees sometimes hold workshops to iron out differences between opposing groups before bills are written. Last year, when the Florida Dental Practice Act was sunsetted, a workshop was called by a legislator friendly to dental hygienists. I believe some of the gains made in that legislature by dental hygiene may have been due to the results of the workshop. Although the opposition did not offer any compromise at the time; in fact, they refused to put their cards on the table; the hygienists were open and honest about what they wanted and I suspect they gained sympathy from the legislators. I know for certain that the chair of the subcommittee was sympathetic because he arranged the workshop and has stated that he believes independent practice is in the offing. He understands the hygienist's plight because he is a pharmacist. It's vital to nourish this type of relationship. By the way, he's the one who related the story of the cosmetologists--so you can't afford to throw the chauvinist out with the bath water.

What happens the last weeks of the legislature? How can you make sure legislation is not blocked? What are the procedures for conference committees? For overriding gubernatorial vetoes?

The last weeks of the legislative session are crucial because this is when most legislation is passed and when many deals are made. You need to make sure that your bills are not blocked in a logjam.

After one house passes a bill, which may have a companion bill in the other house, a committee made up from members of both houses may meet to reconcile differences. The work of these conference committees must be carefully scrutinized.

Here the final bill is written and at this point compromises are usually made. Your group needs to monitor the process and be prepared to change focus if necessary. Compromise seems difficult for women. We've traditionally been the defenders of right and wrong and have acted as society's conscience. We need to learn to maintain our integrity as women while recognizing the expediency of the moment.

So, be prepared to compromise and perhaps to wait a period of years before making significant progress. But don't forget that the very recognition of your group as a force to be dealt with is a beginning. The gains you make during a session may have little relation to your original agenda because you will learn to exploit possibilities unknown to you before the session begins. Campaign finance reform has been an elusive goal of Common Cause Florida for ten years. Last session the retiring Senate President decided to press for public financing of political campaigns as his swan song. Common Cause had no previous knowledge of this, so we had to drop other priorities and concentrate on that issue and it paid off.

Concentrate your efforts on the undecided legislators. Get those who support your issue to approach the "undecideds". You will rarely succeed in changing the mind of someone who already feels strongly on the issue.

Get to know the capitol press corps and encourage your members to make media contacts in their hometowns. If you can give the press useful, novel, accurate information, you make an important contact. Don't ask them to cover your meetings unless something spectacular is going to break. And don't be offended if they don't use the information you send them. Remember, the members of the press are not public servants. A few charismatic people can capture the imagination of the press. I know a public interest lobbyist who said to the press: "We caught the legislature with their pants down." He made headlines frequently and the press loved him but he was always accurate as well as flamboyant. That's not my style so I wouldn't attempt it. I play it cool and go for credibility. If the subject is controversial, like some I have lobbied, you don't have to be outrageous to attract the attention of the press.

In closing, I encourage you to seek expert instruction before lobbying. Set general but flexible goals. be responsible to the needs of students and the public. Get to know your lawmakers and capitalize on personal relationships between them and your members.

Form coalitions with appropriate groups - the disaffected members of society, dental assistants, dental technicians, other allied health professionals and dentists when possible. There are forces which hope to drive a wedge between assistants and hygienists. If they succeed, you will lose big. Don't forget the unlikely allies. John Gardner

says, "We have no permanent enemies." 'Tis true that politics makes strange bedfellows and today's adversary may be tomorrow's ally. For example, the issue of Pep-C's objection to accreditation in Florida could bring together dentistry, dental hygiene, and all other health occupations.

Get your troops fired up and plunge right in. You'll learn a lot--fast. The legislative process seems complicated and can be frustrating at first. But it is also exciting and rewarding. If you're a combative person, you'll love it.

INTRODUCTION: BRENTA DAVIS, EdD

Cheryl Westphal, RDH, MS

Webster's Ninth New Collegiate Dictionary places first common usage of the phrase "Renaissance man" in the early 1900s and provides the following definition: "A person who has wide interests and is expert in several areas." Speaking in the late 1980s, I would favor substituting "person" for "man", and suggest that our next guest, Dr. Brenta Davis, Assistant Dean for the College of Allied Health Sciences at the University of Tennessee Center for the Health Sciences, exemplifies Webster's definition. A medical technologist and clinical lab scientist, Dr. Davis received a bachelor's degree from the University of Tennessee and a master's and doctorate in education from Memphis State University.

She has encountered many of the issues that face us today as members of the health profession, in her roles as clinician, faculty member, program director, continuing education program coordinator, educational consultant, and in her current appointments at Memphis State University as Assistant Professor of Pathology, Professor of Clinical Science, and Assistant Dean of the College of Allied Health Sciences.

She has demonstrated her interest and commitment to the future of health care education through her numerous professional activities, presentations and publications. She is active in numerous medical technology and allied health professional organizations as a member, officer, and committee chairman.

Her collegiate activities include participation on a variety of faculty and university committees in both undergraduate and graduate education. And her community work has extended past local and state circles into the national arena.

Dr. Davis has addressed, through presentation and publication, a variety of timely concerns including: current clinical topics, the role of research in education, federal impact on health care and its delivery, changes in health care and the impact on health education, and issues in higher education such as credentialing, accreditation, and competency.

Given her wide interests and expertise in the issues germane to our discussion, it is more than appropriate that Dr. Davis be with us today to address the external forces influencing innovation. She has experienced the external forces in a variety of arenas and it is with great pleasure that I welcome her now to share her experience and expertise. Dr. Davis...

EXTERNAL FORCES INFLUENCING INNOVATION

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I'm particularly pleased to be asked to be with you as you grapple with the professionalism and professionalization of dental hygiene. It is true that this is a workshop on articulation and innovation in dental hygiene education; but you have set for yourselves the very worthy goal of moving dental hygiene from a technically based to a knowledge-based profession, one that is recognized as such by others, external to your group. That is a goal unmistakably identified with the professionalization process that sociologists tell us is inevitable among all occupational groups, particularly those aligned with health care, such as yours and mine. Yes, I and my colleagues in medical technology have trod and are treading this selfsame path with you. We've been at it longer, perhaps, but in any case, there is much similarity between us, not only in our goals, but also in the ways we've sought to achieve our goals, and thus, there may be things I can share with you about the external forces out there that can help or hinder your journey. By the way, I have defined "external" as anything outside the dental hygiene department of an educational institution.

As I will shortly demonstrate, an educational process of the sort you hope to accomplish is a key, if not the key element of recognized professions. Thus, you are quite rightly exploring alternatives available to you to accomplish your professional goals, and once again, I think I can share some experience and some information that may help all of us.

And what do we want? I suspect that if we could go around the room and ask each and every one of you, we might get as many different specific answers as there are people in the room. My guess is though, that your answers could be more or less characterized as follows: What we want is the opportunity to competently practice our profession in a way that brings recognition and respect for our competence and professionalism, as well as rewards that are truly reflective of our contribution to the health and well being of others. In a word, we want to achieve true, recognized professional status. I say this with some confidence because, as I've indicated, I've been involved in exploring this issue in some detail for quite some while now. I first explored it as a part of my activities with my own profession, then as a graduate student exploring professions and professionalization in general, and most recently as an academic administrator in a college of allied health. To my surprise and chagrin, I discovered that I didn't discover this topic; professionalism has long been a favorite topic of sociologists who've been studying professions as a social phenomenon for years!

On this rocky road to recognized professionalism I expect that dental hygienists have experienced some of the same problems medical technologists have had with respect to professional recognition, or the lack thereof: we medical technologists have experienced a great deal of job stress; insufficient authority for the amount of responsibility

we had; low salaries; lack of image and respect; working conditions set by another profession that didn't really want medical technologists to work at our highest level of capacity. These are problems that cry out against the lack of recognition of the professionalism and competence of medical technologists and perhaps dental hygienists, too, if that story sounds only too familiar.

The desire for improvement in these things seems universal. It's a cry for the achievement of the goal of full, recognized professionalism. But is that really what you want? Indeed and in fact, I'm not sure all of us have made that decision yet, despite the apparent commitments we think we've made over the years. But we as individuals can't avoid deciding whether we really want to be the professionals we often say we are. Because it isn't enough just to say so--everybody these days says he is one--from golfers to hairdressers to plumbers. Not that there is anything wrong with any of these things, but the word "profession" means something very special to us and not just something one does for a living. Profession and professionalism to us, I think, means having certain attributes, certain characteristics, certain prerogatives but certain obligations as well. But you aren't born a professional--you become one. And this "becoming" is not a passive undertaking; rather it is an assertive, active, risky, gutsy declaration of who you are and what you are and what you expect in return for your dedication. Being professional also means being committed enough to weather the storms and difficulties that temporarily accompany any change of significance. And what dental hygiene is proposing to do in its educational arena, i.e., to move toward the baccalaureate as the entry level, is certainly a change of great significance to you and to others.

I must say I think you come to this point in your journey toward true professionalism at an opportune time with respect to certain external forces. Society in general is in the process of reexamining its beliefs about health, health care, those who provide it, and most important, what it's worth in the context of other social, economic, and political concerns. Some of the traditional and historical beliefs about medical and dental care that have truly been sacred cows for so long are trembling, and indeed some have toppled even as we speak. You, as many of us in the health-related professions, are fortunate to be able to occupy the "high moral ground" of advocacy for the patient through advocacy of your ability to provide certain kinds of care, if only you are permitted to fully utilize your education and experience without artificial barriers of any kind.

There are other related changes all around you that work to your advantage: Consumer choice and cost effectiveness are current influences for change that place all health related professions at an advantage: Cost effectiveness, for example, means using people at their highest level of capability--not their lowest.

To the extent that we understand these influences we will be successful in surviving, and indeed, flourishing, in the new environment these events have created. Because the new environment is indeed a golden opportunity, all of us stand at a critical juncture in our professional lives. We can collapse in a heap, or we can recognize that the answers

to our problems and the achievement of our goals lie within ourselves. But like all true opportunities, there is a great deal of risk involved, because if we fail to seize the moment or fail to take advantage of the opportunity, then we could end up in the abyss that always lies on the other side of true opportunity.

This is where the hard part comes, however. We are at a point where we must, each and every one of us, search our minds and hearts to determine if we really want true professionalism; because, to be professionals in the fullest sense of the word, means you're going to have to establish and defend your own legitimate territory, your body of knowledge; you're going to have to stand up for yourselves in a constructive, but purposeful manner. It means taking risks and maybe enduring some very uncomfortable situations; it means taking responsibility for your own fate and doing whatever must be done to fulfill that responsibility, even if it means changing. Change is not easy for many of us who find, or wanted to find, a safe haven in our work with all the assurance and confidence that direction by somebody else can give. Perhaps we are people who hoped that we'd automatically receive recognition and reward for our contributions to the well being of others. But it doesn't work that way. You can't be recognized and rewarded and shy and retiring and afraid all at the same time. You simply can't have it both ways because life just doesn't work that way.

The reality of our situation in the health-related professions is that, to achieve this professionalism I think all of us want, we are going to have to work for it. The immediate challenge as I see it, is to decide if we want it enough to pay the price of change and growth. There is no such thing as a free lunch, and no matter how much commitment there has been in the past to what the golden promise of true professionalism represents to you, it is quite another thing to commit to the steps which must be undertaken if you are to achieve it, and to commit to the vision which must be summoned to see beyond the natural turbulence of change. So you are yet again at a crossroad in your journey, a journey which isn't easy--but who ever said it would be? You cannot escape the choice--either you act in your own behalf or you'll collapse in that heap I mentioned earlier. Frankly, we all get the future we deserve. It really is up to you, and I applaud you for your courage and your vision to approach your educational processes in the way that you are, even if the answers you find are not always the ones you wanted to hear.

Now, let me address professional education and some of the external factors which affect it, particularly as it is conducted in four-year colleges and universities. To do that properly, I think it may be useful first to talk briefly about why ending up in the university is so important in the scheme of professional things.

Certainly if one sets out to produce a professional by means of an educational process, one ought to know what that product looks like. What is a professional? Sociologists can tell you a lot about that. For example, there is consensus among the experts that there are certain attributes professionals have that nonprofessionals don't have and these can be seen in Table I. Note that possession of a unique

body of knowledge that is intellectual in nature is one important distinction between the professional and the nonprofessional. You've used the term knowledge-based, but it's the same thing. Moreover, sociologists tell us, the knowledge must take a long time to acquire, at least four years according to the consensus, and must be acquired in a college or university setting if it is to qualify as truly professional. Thus, you can see what an important step moving to a baccalaureate level is in your professionalization process.

The professional characteristic of a theoretical body of knowledge is not the only characteristic an occupation must possess, however, if it is to be thought a profession. There are several others, outlined in Table I, which sociologists agree are necessary as well. In the context of my presentation, all of these are important in the task of actually producing professional graduates by means of some sort of educational process, and all are affected by external forces. I present all of these characteristics of professionalism together because the quality of professionalism is molar, to borrow a concept from chemistry; that is, while we may talk as though the professional condition is composed of separate elements, such as a unique body of knowledge, the fact is that it is not possible to tease out one element entirely by itself without dragging something of the others along as well. All of these elements are inextricably bound together to produce the whole creature known as a professional.

Thus, the education of professionals must ultimately address in some way, this whole cloth, even though for instructional and other purposes we may address the various fibers of the whole cloth as though they were separate entities. And what is this final product--this animal called the professional? What is its function? Its reason for being? The answer is, as Carr-Saunders has said, to supply a skilled service to ordinary people who are in great need. Not just any old skilled service, but one which is so critical to people that to do without it when they need it would be very harmful to them. Moreover, it is a service which people are willing to believe and trust is being provided in their interest, rather than solely in the interest of the provider. Now, this is not an easy credibility to gain or to keep as our colleagues, particularly in medicine and law, have learned.

To gain and keep such trust from people, there must be what Lewis Mayhew has described as a professional group ethos internalized by the individual practitioner, so that he feels a deep and lifelong commitment to the concepts and precepts of the profession. It is a commitment that goes beyond the work life. For example, the physician, the archetypical professional so far as many health occupations are concerned, is never "off duty". His ethos requires that he assist a human being in medical distress wherever and whenever he might encounter that person. And while we would expect any decent person to try to help a fellow creature in distress, we set higher standards for those whose skills are such that their help can be effective. And so we expect that particular professional ethos to be manifested by physicians, dentists, and other who seek our trust; otherwise we won't surrender our most intimate selves to their care, nor will we grant them the autonomy they claim they need in order to serve us.

It is from these two traits, criticality of the human need and trust, that a number of the other professional traits are derived, including exclusive right to the knowledge and skill that enables a member of the anointed group to deliver! But in the context of a profession and a professional practitioner, without the application of skill, there is nothing; never mind how much knowledge the so-called professional may possess. I say "so-called" because unless the skill is possessed and is applied to real and practical problems in the real world, the individual is not truly deserving of the title of professional, from the public's point of view. And in fact, in the public's view, a person without that skill has little social utility in the context of why professionals exist in the first place. In the public's view, of course, professionals exist only to serve the public.

If one accepts this view of profession and professional, then it becomes immediately apparent that the task of those who educate people to be professionals must be to insure the development in students of the salient skills and the ability to use them. This requires not only practice on the part of the student, but knowledge of underlying principles as well, so that the skills can be applied in a variety of unanticipated circumstances. In other words, professional competence with respect to applied skills is central to the professional function. For reasons that will be addressed later, the skills aspect of professional education may not always get the respect it deserves. But make no mistake, the skill must be there or the educational process which is supposed to produce the professional has failed. And society, a potent external force if there ever was one, will sooner or later respond to this failure by withdrawing its support--either from the institution which went astray, or from the profession if there is a systematic rather than a random problem. Remember that a profession in society's view exists only in the context of its duty to achieve practical social utility. Thus, the overarching goal of professional education is to produce a product, a professional, capable of discharging the duties the public thinks it should.

If a major goal of educators of professionals then is to produce a skilled practitioner, how does one teach the necessary skills and at the same time inculcate into the neophyte the group ethos or culture so necessary to maintain the public trust and sanction on which the whole house of cards is built? One answer to this question that everyone seems to agree on is that the aspiring professional must be in contact with and taught by a skilled practitioner of the profession. Moreover, a substantial portion of this mentorship must occur in as real a setting as possible preferably beginning in a carefully controlled or simulated environment because of what we know about skills learning, but moving to the real thing--the hospital bedside, the clinical laboratories, the dental hygiene clinic, and other settings.

Setting aside the question of how competent a teacher the professional mentor may be, without him the budding professional won't ever flower. Thus the educational process for professionals must include this kind of teacher, as well as those whose orientation lies elsewhere, such as research. And basic research is "elsewhere," it is not the practice

of the profession. Those who are committed primarily to basic research are not practitioners, even if once they were. Practice implies active use of the professional skill. And so basic researchers cannot easily perform the mentor role so critical to the production of a competent professional.

This brings me to one of the external forces you will face in the university that is problematic, and that is increased pressure on those of us in academia to have doctoral level faculty who are engaged in basic research. This pressure has to do with the academic acceptability of our faculty within the university community in which we live and compete for resources.

This is a real problem, because if I wish to focus on the preparation of a professional, in this case a dental hygienist, then I am going to surround myself with knowledgeable and skillful practitioners both in the classroom and lab and in the dental hygiene clinic. These would be people who vigorously espouse the precepts and the ethos of the profession and who diligently work at socializing the neophytes into the professional culture. On the other hand, if I must focus on the academic acceptability of my unit, acceptability which seems to be based on the current coin of the realm, doctorates and research/publication, then I am going to have to find some dental hygienists with PhDs whose major interest is research that can get published, preferably basic or pure research, and let them have at it. Of course, they're also going to be expected to teach dental hygiene students, but I'll need a whip and a chair to get them into the classroom, much less to a clinical practice site; but even if I could get them to the clinic, no one will welcome them because, in developing their basic research commitment, these individuals no longer have current professional skills, and these skills are the coin of the realm in the professional world.

Now, I have used some hyperbole, but not much; and if you have followed my argument so far about what a professional is and therefore what it takes to produce one, you can see I have a problem here. If I succumb to the pressures I feel all around me to be viewed as "acceptable" and my faculty promotable, I must acquire PhD faculty who not only do pure research and publish it, but get big grants to do so; but then I have, in fact, severely compromised if not destroyed my ability to produce professionals competent enough and socialized enough into dental hygiene to be turned loose on the public.

Why in the world do we have this pressure for so-called academic legitimacy to be paid for in the traditional academic coin of the realm? Because, and this is very important to understand, traditional academics are setting the ground rules for faculty appointments and promotions. And instead of primary value being placed on practical service to people, the traditional academic is dedicated by virtue of his training to elucidating abstract truth from whatever discipline he is attached. He is dedicated to the cognitive process itself as an end in itself, rather than the means to practical human problem solving. This latter notion is a major distinction between these two animals.

And indeed, when viewed from this perspective, I believe you can see that we are talking about two very different animals here--the professional on the one hand and the traditional academic (basic researcher) on the other. Their missions in life, their reasons for being are very different, thus what it takes to educate and to nurture each is very different. Yet, as I've said, the traditional academic got to the university first and so the notions in place of what's worthwhile are his, as well as the focus on the cognitive and the abstract rather than the practical and the human.

I have spent a good deal of time elucidating this particular external factor awaiting you at the university, because unless all of us in the health-related professions deal with this problem well, I assure you it will become the most significant external force, if not outright barrier we all face. Those of us who got there before you certainly haven't solved it yet, and so we welcome you to the continuing search for a solution.

There are certainly going to be some other external forces as you strive to change the focus of your education and to achieve your professional goals. Some are general forces and perhaps well known, but at the risk of belaboring the obvious, I want to mention some of them, because they are positively killers if you don't take them into account. First, human beings resist change, no matter how worthy the change or how much they may agree with it in principle. No doubt there is some physiological basis to this. The human organism craves equilibrium. In any case, to the extent that there is any lack of agreement about the desirability of the change, there will be even more resistance and turbulence surrounding it. Leaders who are skilled change agents and who can maintain a clear vision of the ultimate goals desired are especially needed at a time like this.

Often the dispute is not about goals, but rather over the means to achieve them. And that brings me to the second general factor I want to mention. Except for true martyrs, and those are few in number throughout history, people, even good people, do not act against what they perceive as their own best interests, even to achieve worthwhile goals. Your perception of what's in someone's best interest and their perceptions are not necessarily or even often the same. Reason and logic have no power if a person believes that he would be hurt somehow by doing what you want. Thus, you will no doubt experience at one time or another continuing, willful recalcitrance, despite your most brilliant and logical arguments for innovation and cooperation and your most passionate pleas for the welfare of the patient or the student or whatever. Remember that most of us have to see if not benefit from that, at least, lack of harm to ourselves before we will act to change anything, no matter how worthy.

Now, let me address some external factors more specific to the higher education environment in which baccalaureate education takes place. Given that you have consensus on the career entry baccalaureate as a goal for dental hygiene, I hope this workshop means that you are moving toward consensus on how this will be accomplished among two and four-year institutions. Although many of the external forces having

influence at the community college level are similar to those at the four-year institutions, there are some differences that I believe you should be prepared to face. In any case, these forces are extraordinary these days, and I would hope and urge that your collective energies as a profession can go into meeting these external forces successfully, rather than being consumed and fragmented in internal struggles and conflict. I say this to you from sad experience in my own profession.

As you move forward, you will need a reliable source of the kind of information about higher education, so that you can try, at least, to stay ahead of the hounds. Just as the financial community has the Wall Street Journal, higher education has the Chronicle of Higher Education. I'm sure many of you are familiar with this weekly publication, and my advice is to gain access to and read it.

One of the circumstances you will encounter is fierce and maybe even vicious competition for students. And, make no mistake, research on college students leaves no doubt that the majority go to college so that they can become, in their words "well off financially" and "have a secure future." So, for all of the health related professions the old recruitment question of "who are we looking for" must be joined by the new question of "who is looking for us." Successful recruitment means creative recruitment and a real understanding of the student market out there. There have been some significant changes in student demographics in recent years and some brand new trends which have been highlighted in Table 2.

First of all, the current baby boom is over. Since 1982, the final baby boom year, college enrollment has dropped significantly, and for the first time, the 1986-87 academic year enrolled more females than males. The number of part-time and older students has increased dramatically, while the number of full-time, 18 to 24 year old students is decreasing. Moreover, these students are financing their educations by borrowing: one-third to one-half of all students leave college with debts, five times the number of just a decade ago. Most students stay close to home with 86 percent enrolling in public institutions in their home states.

Those are the "bones" of our picture of present day college students whom we must attract to our programs. Now for the "flesh"--what will attract them? What are they looking for? One way to find out is to focus on incoming freshmen each year and ask them. The American Council on Education has been doing this for over two decades. Recently they reported the findings of the 1985 survey and found some interesting, though not surprising, contrasts between freshmen of 1967 and 1985. (See Table 3)

Students these days, both male and female, are more concerned than ever with a secure future and being well off financially. They see college and a baccalaureate degree as the way to that future. They are gravitating toward business majors and away from the traditional professions, and women are right in there with the men. Although no one would deny that some occupational and professional discrimination

against women still exists, it certainly has diminished to the point that so called traditionally female professions are having to compete for students among a greater variety of career opportunities than they used to. Moreover, attitudes about working wives have changed over the years. There is more interest in career specific majors and less in the traditional liberal arts fields. No doubt the concern about financing an education and getting a job has resulted in less time to contemplate the meaning of life.

Although ensuring good applicant pools and full classes will occupy a good deal of your time, living and holding your own within the academic community of the university, the community of scholars, will require your attention as well. You must compete for always scarce resources with the more traditional academic and professional disciplines who, after all, got there before you.

What about the general environment in which colleges and universities must exist? Except in a few states where the oil based economy has hit bottom, state support for public higher education is, on the average, up 14% over the past two years. Make no mistake, competition within the institution for these dollars is keen, but at least the pie, however small it still is, is growing, not shrinking. There are a number of reasons for increasing support of higher education: People have begun to connect economic prosperity and educational quality at all levels. At the same time a number of national studies have cited the lack of quality in American education as a serious problem, and the public is willing to spend money to correct these alleged deficiencies. So, education has been rediscovered.

While these national studies have resulted in a number of benefits to higher education, they have also sparked debate that you will undoubtedly be drawn further into. These include the debate over how educational quality should be measured, by outcomes or by process. There is also the increasing complaint of liberal arts faculties that an emphasis on "careerism" in higher education has virtually eliminated the truly educated person from the scene. There is also the chronic debate over the purposes and functions of accreditation. What is important for us to remember as we join the fray is that there are at least two sides to these complicated questions, and all of us must become careful, analytical consumers of the data and the arguments that proponents of various points of view bring forth to support their position. Ironically, disagreements about accreditation or curriculum are often less about education than about power and control.

You will also find that the university doesn't move on things quite as quickly as the community college does, perhaps. The university, after all, has about a thousand years of traditional baggage to drag around and believe me, it wouldn't dream of leaving any of it behind. On a more practical level, however, the university of today has many constraints that do not permit rapid, unilateral changes of any major significance. Almost all states now have some sort of centralized public agency which oversees higher education. Budgets, new degree programs, long-range educational planning, you name it, fall within the purview of these agencies whose responsibility is to see to it that the

state's education money is spent wisely, so it may not be enough for a single institution to decide to offer the baccalaureate in dental hygiene. The political machinery of higher education in the state must agree as well.

I have, concentrated on external factors at the state level which directly affect us the most, because in the United States education at all levels is a state rather than a federal responsibility. Of course, there is a federal Department of Education, federal loan and grants to students, federal funding of research, federal recognition of accrediting agencies, and on and on, so that despite the U.S. Constitution, as a practical matter, the federal government certainly has a great deal of influence on higher education. Except for the specialized accreditation issue, such influence often affects whole institutions, however, rather than isolated departments or programs and universities usually have very sophisticated government programs and staff who can keep us informed.

As you can see, the ivy covered halls of academe are far from the quiet, deliberative, stable sanctuaries that people often think they are. On the contrary, the university is a seething jungle and those of us who come to it from the rather straightforward professional world must learn quickly to read the signs and recognize the tracks of all the other animals and forces therein.

Well, despite the difficulties these external forces may present, the prize of recognized professionalism that you seek is, in my view, well worth the struggle. And as I observe you, what I see excites me a great deal, because I have every confidence that you have the resources and the moment in history when it can all come together for you. But, if you will permit me as a battle hardened warrior in the professionalization wars, I'd like to point out an element which I think is key to any journey toward true, recognized professional status. I've discussed this before, but there is an important factor which should be noted. Understand that a cohesive, active, even aggressive professional association is the glue that holds everything else on the professionalization list together.

Achieving professional status takes more than competence and dedication--it takes courage and unified action by thousands of individuals who believe in themselves and in their profession. Getting what you want is not easy, but I assure you that if you believe that you are powerless, you will be; I assure you that as long as you permit others to direct your destinies, they will; and if you believe there are no solutions, there won't be. You have it within you to be whatever you choose to be.

Your professional organization is the vehicle by which you can achieve your goals. It is the vehicle by which you as an individual can draw sustenance and support, and strength from the thousands of others engaged in the same struggle you are. American Dental Hygienists' Association is the way you know you're not alone. Together, all of you are so much more than any of you could be alone. Together, you have the means and the energy and the vision to be whatever it is you want.

I wish you every success as you make your way towards true professionalism. If you continue as you seem to be, I have no doubt that you will make it.

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TABLE I

Characteristics Of Recognized Professions

- . A unique, intellectual body of knowledge that only others in the same profession possess.
- . Practical skills derived from the body of knowledge that are competently applied to critical human problems.
- . A sense of duty toward the welfare of patients such that they can trust us, not only to know, but also do the right thing.
- . Control over all matters relating to the profession, such as:
 - who enters educational programs.
 - who can take and who can pass certification and licensure exams.
 - what work is to be done and how it should be done.
 - what constitutes quality performance.
- . Esteem and recognition from others.
- . A professional organization and a professional "culture" of shared beliefs, values, and symbols.

TABLE II

Trends in Student populations

Decreased 18-24 year old students
 Decreased full-time students
 Increased older students
 Increased part-time students
 Increased women
 Increased student debt

TABLE III

ACE
 Annual Freshman Survey
 Results

<u>Issue</u>	<u>1967</u>	<u>1985</u>
Preoccupation with a secure future	44%	71%
Development of philosophy of life important	83%	43%
Believe married women should stay at home	57%	22%
Financing education is a major concern	9%	14%

INTRODUCTION: BARBARA NELSON, RDH, MS

Cheryl Westphal, RDH, MS

At this point we have addressed a variety of issues related to articulation. It may be helpful to now examine existing collaborative efforts; how and why they were developed, and their evolution and status today. Barbara Nelson is involved in an educational collaborative effort in Nevada and is with us today to share her experience with this exciting new model.

She is the director of the Dental Hygiene Program at Clark County Community College in the University of Nevada System. She received a bachelor's degree in secondary education and a master's degree in postsecondary education from the University of Nevada. As a dental hygiene program coordinator and tenured faculty member, Barbara Nelson has served on numerous college and university councils and committees addressing issues concerning academic planning, accreditation, faculty selection and tenure review, and student selection.

Her involvement within organized dental hygiene includes service in varying capacities at the local, state and national level. She is also involved in a number of educator organizations including the American Association of Dental Schools, Nevada Faculty Alliance, Nevada Vocational Association, and the California Dental Hygiene Educators' Association. And she is currently a consultant to the ADA Commission on Dental Accreditation.

Today, she will describe the process she undertook to develop a collaborative effort between Clark County Community College and the University of Nevada. It is my pleasure to introduce Barbara Nelson.

ARTICULATION: A PROJECTIVE MODEL
Barbara Nelson, RDH, MS
Director, Dental Hygiene Program
Clark Community College, Las Vegas, Nevada

There has been a shift in the fundamental values placed by society on its health education delivery system as evidenced by public insistence on greater accountability. Educators are subject to more intense pressure than ever before to increase curriculum content, provide quality education, and reduce the cost of delivering educational services. Rapid advances in recognition and treatment of disease place greater emphasis on the comprehension of a larger body of knowledge than in past years. The curricula of health care educational programs are swelling with added responsibility and wider scope of practice. Federal and state monies that have been available to support health education programs are ceasing to exist. We are called upon to devise ingenious plans to educate more students at less cost.

Examining dental hygiene from an historical perspective, we can see the profession slowly emerging and in many ways duplicating the path that other health professions have travelled. The American Dental Hygienists' Association (ADHA) was established in 1923 about the time that schools of medicine were becoming four-year programs with prerequisites. Prior to 1937, the dental hygiene curriculum was less than two years in many cases. In 1940, the ADHA Board of Trustees recommended that the course of study for dental hygiene be not less than two years.(1)

Federal legislation has had significant influence on dental hygiene education. The Vocational Education Act of 1960 (Public Law 88-210) and other legislation had a decided effect on the number of dental hygiene programs in the United States. During the period of 1960-1969, the number of dental hygiene programs rose to just under one hundred. From 1970-1973, the number grew to 160.(1) Today there are over 200 programs in the United States. Compare this boom to the rapid increase in the number of nursing programs during that period.(2) In both cases, the greatest percentage of growth has been in the two-year vocational programs. Certainly the impact of federal monies available to vocational programs is apparent. Vocational education programs are defined by the federal government as "...programs which are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree" (Public Law 94-482). This definition would indicate that one of the main reasons the two-year programs experienced such phenomenal growth was the impetus from the federal government in the form of tax dollars.

In June 1951, the ADHA held a conference to discuss the dental hygiene curriculum. The two-year course was deemed adequate to prepare the dental hygienist to perform in the private dental office. However, when employed by a school system or any other agency, the basic dental hygiene education was viewed as foundation for further study. In 1968, the House of Delegates of the ADHA adopted a resolution defining the certificate and/or associate degree as the entry level credential and

outlined some basic differences in the associate degree and baccalaureate degree programs. It was at this time that entry level issues were brought to light.

We have come a great distance since the 1950s when a two-year program seemed adequate. In a 37-year period, we have added considerable content in dental hygiene education. New responsibilities in dental hygiene services are stretching the two-year curriculum to its maximum. In states where expanded functions are legal, the educational programs are painfully overloaded. It is not unusual to see a "two-year curriculum" with 94-120 semester credits. The two-year curriculum is in actuality perhaps a three or three-and-one-half year curriculum. Is there really a difference between the two and four-year curricula other than a few methods and humanities courses?

Nearly ten years ago, Dolores Malvitz, in her presentation at the "National Invitational Conference on Dental Assisting and Dental Hygiene Education" questioned,

Are we primarily focusing on vocational preparation, or on a broader liberal arts education?...Can we provide students an academically oriented education in an environment suspicious of the academic trappings? Or, can we truly develop respect for technical skills in an academically rigorous setting?

The time has come to evaluate the direction health professions will take in the near future. According to Kraemer (3), "Where possible, existing associate degree programs should be modified and converted to baccalaureate programs to allow students to earn the baccalaureate degree." Many questions arise. Will the high cost of health education programs prevent their progression to the four-year colleges and universities? Will the academic philosophy of universities tolerate the clinical environment of the dental hygiene program? We may be overlooking alternatives to this complicated problem of swelling curriculum. Perhaps the community college can be an important part of this solution.

In his address to the 59th Annual Convention of the American Association of Community and Junior Colleges, Robert Kinsinger states,

Articulation with baccalaureate granting institutions offering health related programs should be re-examined...obviously arrangements between community colleges and other institutions are essential in building effective career ladders.(4)

Dental hygiene is now faced with many issues. How will we respond? Will we agree to investigate educational articulation? There are many positive opportunities for two-year colleges in this process. Perhaps we should explore the possibilities with some pertinent questions:

1. Should a two-year college formulate plans to develop and articulate a two-plus-two dental hygiene program with four-year institutions? In this setting, the two-year

college could assume the responsibility for the technical education and the four-year college would assume responsibility for the professional capstone.

2. Should dental hygiene approach a one-year prerequisite, two-year dental hygiene curriculum, and a final year at a four-year institution?
3. Does the philosophy of vocational education conflict with or complement the dental hygiene curriculum philosophy?
4. Is dental hygiene responding to national trends?
5. Can the baccalaureate degree granting institutions accommodate the proposed articulation alliances?
6. Will dental hygiene education eventually phase out of the two-year structure?

Each question in itself could develop into an additional treatise. We must assess our position, and avoid conflicting dictates. We can observe the body of knowledge constantly expanding in our profession. How we respond to this situation remains to be seen.

As the profession moves ahead to define entry level as the baccalaureate degree in dental hygiene, the two-year dental hygiene program could remain as the pre-professional preparation. The four-year institution could easily accommodate the two-year graduate much the same as the four-year college accepts the first two years of any discipline toward the baccalaureate degree.

My task today is to present to this body the results of one state's attempt at a one-plus-two-plus one conjoint curriculum. It is a collaborative effort of a community college and a university within the same educational system.

Why did our institution embark on this colossal project? Partly, it was due to the fact that we were responding to faculty and student concerns regarding number of credits earned in an associate degree. Currently our graduates earn 94 credits hours and are awarded an Associate of Applied Science. At the local university, a baccalaureate degree in the College of Health Sciences requires 128 credits. It's not a difficult comparison--34 additional credits for a baccalaureate degree.

In the Community Dental Health Class in 1984, a group of dental hygiene students asked to develop a proposal to present to the college curriculum committee. The proposal would encompass a needs assessment, a study of other programs in the United States, and a proposed curriculum transfer program to the university.

The project was completed and, while not earth-shattering in its findings, it served to provide the impetus we needed for further

investigation. The student researchers found that 83% of the graduates of the community college had considered pursuing a baccalaureate degree. (5)

Concurrently, the Director of the Division was developing a model for an articulated medical laboratory technology program between the community college and the university medical school.

The Medical Laboratory Program under development between the community college and the university medical school was developed as a new model with a conjoint feature. The dental hygiene curriculum would be patterned after this model.

Initial inquiries were made at the director/dean levels at the community college and the university to initiate an articulated conjoint dental hygiene curriculum. Meetings were held in fall 1985 to develop basic points of agreement.

The first document developed covered the following:

1. Areas of responsibility for curriculum planning, implementation and evaluation.
2. Establishing Dental Hygiene Coordinating Board (DHCB).
3. Delineating the DHCB's responsibilities.
4. Establishing workloads at both institutions. This was critical because each institution had different requirements for workloads.
5. Hiring of the Dental Hygiene Program Coordinator and faculty.
6. The establishing of joint appointments.
7. The awarding of degrees (AAS at CCCC - BS at University).
8. Transferability of credits.
9. Agreement regarding which institution offered courses and where fees were to be paid.
10. Faculty assignments.
11. Articulation between institutions.
12. Responsibilities to accrediting agencies.
13. Program admissions policies.
14. Recruitment costs.
15. Make-up of advisory committee.

At the Vice President's level, congratulations were forthcoming regarding the proposed articulation agreement. It seemed almost too easy...we were on our way! As the Dental Hygiene Program Coordinator, I was asked to develop the curriculum. A conjoint capstone program in dental hygiene was developed in which the community college awarded the associate degree and the university awarded the baccalaureate degree (Figures 1 and 2).

Efforts were made to utilize courses currently offered in the university catalog. This would keep costs at a minimum while the program was developing.

Prerequisites to the dental hygiene program could be taken at either the community college or university and included the basic science and general education courses. One year would be required to complete these courses.

Admission of students to the dental hygiene program would be a joint responsibility and would follow a mutually acceptable procedure and standards that would be coordinated by the dental hygiene program coordinating board.

The community college would award the Associate of Applied Science degree in dental hygiene and those students would be eligible to enter the baccalaureate program in dental hygiene at the university as seniors; provided they had completed sufficient of their general education requirements to meet the earned-credit-hour requirements for senior status.

The university would offer its didactic major concentration courses on a regular schedule. These courses would be offered at the community college campus except where offering them at the university would not place an undue scheduling burden on students or faculty.

The curriculum is arranged so that prerequisites could be taken at either the community college or university. Beginning in the spring of the first year in the dental hygiene curriculum, the student takes courses through both the university and the community college. The student is concurrently enrolled at the university and community college. By the second year in the dental hygiene program, only the clinical phases of the curriculum are taught at the community college level, and all other courses are taught at the university level. At the end of the third year (one year prerequisite and two dental hygiene) an associate degree is awarded by the community college.

The student may exit with 92 to 94 credits and an AAS or continue at the university, picking up those requirements necessary for the baccalaureate degree. There is a required general education core of 15 credits plus 12 credits of upper division dental hygiene. Additionally the student takes seven credits in one of three areas or concentrations. The three areas are forensics, myofunctional therapy or hospital dentistry. One hundred twenty-eight credits were required for the baccalaureate degree.

The dental hygiene faculty would be jointly appointed at both institutions. The terms of the joint appointments and the workload and other personnel policies related would be developed and approved by both institutions.

A coordinating board would be comprised of the University Dean of Health Sciences, the Community College Director of Science and Health and the Dental Hygiene Program Coordinator. The coordination board acts in unison and would be responsible for an annual review of curriculum and program effectiveness, instructional quality and staff

development; and would initiate program changes or modification. The coordinating board would be responsible for the administrative and coordinating aspects of the conjoint program.

The Dean of the College of Health Sciences sent out a survey to the community to establish a need for this program.(6) Both dentists and dental hygienists were very interested in the prospect of a baccalaureate degree program. Most perceived that a BS would bring no grater salary benefit, but would provide greater professional status. When asked if they would support the concept of baccalaureate education 86% of the dentists responded affirmatively. Sixty-three percent of the dentists would assign additional responsibilities to the baccalaureate degree dental hygienists (BSDH). However, when given a choice between hiring an associate degree dental hygienist (ASDH) or a baccalaureate dental hygienist, 30% would hire a BSDH, less than one percent would hire an ASDH, and 65% would hire either.(6)

Barriers to Implementation

1. When hiring personnel, it made no difference to 65% of the dentists in Nevada whether the hygienist had an AAS or BS degree. Currently, the only employers of dental hygienists are dentists as Nevada's law requires a dentist present whenever dental hygiene services are performed.
2. The university and community college became deadlocked in a fatal battle--faculty appointments. The university determined that two new positions would be needed to implement the program. The community college could not give two positions to them. The full-time equivalent (FTE) formula drives new positions at all institutions within the state.
3. Workload at the two institutions is not equal. The community college workload is 15-credit hours. The university workload is nine hours. If community college faculty would receive joint appointments their teaching load would automatically be reduced--thus driving costs up.
4. The university felt that if students could exit with eligibility for practice at 94 credits few would go on, making a very expensive 4th year.
5. Title IV of the Higher Education Act of 1965 prohibits using two institutions simultaneously to qualify for financial aid purposes. A dental hygiene student would always be part-time. This greatly reduces the amount of assistance to the student.

A second option has been presented to us. That is to utilize the health administration baccalaureate degree at the university. It would require more upper division credits, none of them in dental hygiene.

Our first choice is still the baccalaureate degree in dental hygiene. If the legislature awards additional positions, we can move toward this goal.

There is still a general atmosphere of collaboration, but several barriers remain. New light has recently been shed on the problem. The community college and the University Medical School are embarking on a joint project. A new medical-dental clinical facility has been donated to the university system. Upon completion, this separate location may provide more than a clinical site. Initial explorations are being made offering a baccalaureate degree through the medical school rather than the university. This would closely follow the pattern established by the conjoint Medical Technology Program. As Dr. Lugeneel stated, "Be patient, and expect small miracles." "Change is slow."

Looking ahead, we have identified our barriers, and now we must overcome them. It will not be simple, and it will be challenging; but we never make any significant advances without a few steps backward.

It is during those few steps backward that we stop to get the larger perspective. We will continue to assess our progress and move toward the solution.

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FIGURE NO. 1

Proposed Degree Requirements
BS in Dental Hygiene

	UNLV Gen. Education Core Requirements		Met CCCC	Additional Needed
I.	English Composition	= 9 cr.	3	6
II.	Logic, Math, Computer Science or Statistics	= 9 cr.	0	9
III.	Constitution Requirement Political Science 101 History 101/102	= 4 or 6 cr.	4	0
IV.	Social Science Anthropology, Economics or Social Science	= 9 cr.	6	3
V.	Science Physical and Biological Sciences	= 18 cr.	18	0
VI.	Fine Arts and Humanity	= 3 cr.	0	
	Core Requirements	= 52-54 cr.	34	18
VII.	Lower Division D.H.	= 35 cr.		
	HPC 117 Medical Terminology	= 2	HPC 165 Pathophysiol.	= 3
	DH 202 Oral Biology	= 2	HPC 108 Interpers. Skills	= 1
	DH 203 Head/Neck Anatomy	= 2	DH 212 Oral Radiology	= 3
	DH 204 Dental Hygiene I	= 3	DH 215 Clinic. Pract. I	= 3
	DH 205 Intro. Clin. Practice I	= 2	DH 305 Clinic. Pract. II	= 5
	HPC 105 Health Care Dynam.	= 1	DH 315 Clinic. Pract. III	= 5
	HPC 125 Pharmacology	= 2		
	BIO 115 Nutrition	= 1		
				<u>35</u>
VIII.	Upper Division D.H.	= 23 cr.		
	DH 304 Dental Hyg. II	= 3	DH 324 Dental Hyg. IV	= 3
	DH 314 Dental Hyg. III	= 3	DH 318 Com. Dent. Hlth.	= 2
	DH 306 Dent. Materials	= 3		
	DH 307 Periodontology	= 3		
	DH 308 Nutrit. Impl. in Dent.	= 1		
	DH 309 Pain Control	= 3		
	DH 313 Oral Pathology	= 2		
				<u>23</u>

FIGURE NO. 2

CONJOINT CAPSTONE PROGRAM IN DENTAL HYGIENE

Program prerequisites may be completed at CCCC/UNLV or other institutions.

FALL	CHEM	110	Intro. Chem. Princ.	4
	BIOL	143	Anatomy & Physiology	4
	ENGL	101	English Composition	3
	HPC	117	Medical Terminology	2
	PSY	101	General Psychology	<u>3</u>
				16

SPRING	CHEM	111	Chem. Princ. II	4
	BIOL	144	Anatomy & Phys. II	4
	SPTH	101	Speech	3
	BIOL	251	Microbiology	<u>4</u>
				15

<u>TERM</u>	<u>COURSES OFFERED BY COMMUNITY COLLEGE</u>				<u>COURSES OFFERED BY UNIVERSITY</u>			
FALL	DH	202	Oral Biology	2				
	DH	203	Head/Neck Anatomy	2				
	DH	204	Dental Hygiene I	3				
	DH	205	Intro. Clin. Pract.	2				
	HPC	105	Health Care Dynamics	1				
	HPC	108	Interpersonal Skills	1				
	HPC	125	Pharmacology	2				
	BIO	115	Nutrition	1				
SPRING	DH	212	Oral Radiology	3	DH	313	Oral Path.	2
	DH	215	Intro. to Clinical Pract. I	3	DH	304	Dental Hygiene II	2
	HPC	165	Pathophysiology	3	DH	308	Nutrition Impl. in Dentistry	1
FALL	DH	305	Clinical Pract. II	5	DH	304	Dental Hyg. III	2
					DH	306	Dental Materials	3
					DH	307	Periodontology	3
					DH	309	Pain Control	3
SPRING	DH	315	Clinical Pract. III	5	DH	318	Com. Dent. Health	3
					DH	314	Dental Hygiene IV	2
					POL			
					SCI	101	Political Science	4
					SOC	101	Sociology	3

-----ASSOCIATE DEGREE AWARDED BY COMMUNITY COLLEGE-----

FALL &
SPRING
Last Year

Completion of general ed. and discipline requirements for
bachelor's degree with 128 credits

Student must take the following additional courses for a BS degree in Dental Hygiene.

General Education Core	=	15 cr.
		15 cr.

HSC 236	Gerontology	=	3 cr.
NURS 472	Women as Health Care Consumers & Providers	=	3 cr.
DH 405	Advanced Practicum in Community Health	=	3 cr.
DH 406	Current Trends in Dental Hygiene	=	3 cr.
			12 cr.

94 + 15 + 12 = 121 credits
Plus one of the following areas

Area I

Anth 467	Techniques of Forensic Research		
OR			
HSC 467		=	3 cr.
Anth 469	Dental Anthropology	=	3 cr.
OR			
HSC 469			
HSC 499	Indep. Study	=	1 cr.
			7 cr.

OR

Area II

DH 401	Myofunctional Therapy	=	3 cr.
DH 402	Clin. Practicum in Myofunctional Therapy	=	4 cr.
			7 cr.

OR

Area III

DH 403	Care of the Medically Compromised Patient	=	3 cr.
DH 404	Hospital Dentistry	=	4 cr.
			7 cr.

121 + 7 = 128 cr.

BARRIERS TO IMPLEMENTATION

1. Ambivalence of dentist - employers to the BSDH. No clear message of support.
2. Faculty positions driven by FTE. Two new positions were needed -- but unavailable.
3. Workload policy would drive up the cost to implement program.
4. No guarantees regarding number of students in BSDH program. University had no assurance that students would continue after 94 credits (AAS).
5. Title IV prohibits using two institutions simultaneously to qualify for financial aid.

INTRODUCTION: MARCIA BRAND, RDH, MS

Cheryl Westphal, RDH, MS

All of us deal with a multitude of systems on a daily basis. We live within a solar system, recent events have focused attention on our political system, we sometimes experience frustration when we interface with a computer system, some of us commute to work on a transit system, we share ideas long distance via a communications system, and we have gathered in Chicago to plan an educational system.

The systems concept is not new. Aristotle developed a "general system of thought." Linnaeus, the 18th century botanist, is considered the "greatest of the systematists." And a German socialist and philosopher contributed to the shaping of modern nations with the creation of a Marxian system.

The whole fabric of civilization is an intricate weave of systems. Not surprising, given their important function. Systems develop out of the need to accomplish goals. To succeed in our efforts we must push our minds to new limits, turn the pieces of the goal to gain a new perspective, and ponder larger concepts. We must think in terms of systems--expanded systems, innovative systems--if we are to achieve our goal.

Marcia Brand has joined us today to speak to this concept. Wearing a variety of hats at Thomas Jefferson University, she is the Career Services Coordinator for the College of Allied Health Sciences, and Associate Professor and Post-Certificate Program Coordinator in the Department of Dental Hygiene.

She received her certificate, bachelor's and master's degrees from Old Dominion University in North Carolina, and is a doctoral candidate in education at the University of Pennsylvania.

In addition to her involvement in this organization, Ms. Brand has held key positions within organizations such as the Americian Association of Dental Schools and the American Association of Hospital Dentists.

Through her educational and professional activities, she has promoted the concept of nontraditional roles and education for dental hygienists and allied health professionals.

Her presentation today speaks to the concept of cooperative agreements through a systems approach. It is my pleasure to introduce Marcia Brand.

COOPERATIVE AGREEMENTS: A SYSTEMS APPROACH

Marcia Brand, RDH, MS
Post-Certificate Program Coordinator
Department of Dental Hygiene
Thomas Jefferson University, Philadelphia, PA

Introduction

In the early 1960s, the United States government established an incredible national goal: to place a man on the moon by 1970. The goal was, literally and figuratively, astronomical. All the classical management theories, and those that were currently in "managerial vogue," seemed inadequate to coordinate the task. What was needed was a way of organizing many groups, agencies, and individuals. The method had to be an extension of the team principle, but instead of individuals comprising a team, the team would be agencies, private businesses, universities, and individual researchers. Some of the members would be part of the central organization, others would be directly controlled by it. Some members of the system would have various tasks according to the stage of the program. Some members of the team were permanent members, while others were involved for only a short time.

The organizational method developed to manage the American space effort was a systems approach. Systems organization focuses on the relationships of a variety of individuals and groups. The systems approach focuses on the whole, rather than the independent organizational segments. The systems approach worked. In 1969, a man walked on the moon.

Very few organizational challenges match the magnitude of the space effort of the 1960s. However, I would venture to say that the task confronting ADHA today seems no less complex. In order to meet the future oral health needs of the public, dental hygienists must become multicompetenced professionals. This will require some major revisions of our educational system and philosophies.

Realistically, providing dental hygienists with the education necessary for the future roles we envision cannot be any more difficult than putting a man on the moon. But perhaps we had better adopt a systems approach in our educational institutions. Then we could organize individuals, agencies, and institutions into teams based on relationships, too.

I am going to describe a systems approach for establishing cooperative agreements between educational institutions. We have employed this approach with some success at Thomas Jefferson University. Our cooperative agreements enable dental hygienists to complete the bachelor's degree by transferring basic dental hygiene credits to a post-certification program. However, I am not promoting

post-certificate dental hygiene education as the method by which dental hygienists should complete the requirements for the baccalaureate degree.

Our task might be a lot easier if we did determine that post-certificate programs were the best way to provide dental hygienists with the education necessary to fulfill the future roles, because none of our existing programs would have to change. Two-year programs and baccalaureate programs could remain in place, and post-certificate education would experience a growth that would delight post-certificate program directors.

However, there is no research upon which to propose a curriculum for the future, and no data that show which educational configurations will enable us to prepare the multicompetencied dental health professional we envision.

To state that one curriculum is best, or another model of articulation is most efficient would be to postulate beyond the information that we have available to us today. However, there are four concepts about which we are certain:

- *We must develop a body of knowledge that forms a theoretical basis for dental hygiene practice.
- *We must conduct research about dental hygiene education.
- *Dental hygiene education must change if dental hygiene is to remain a viable profession.
- *Educational institutions must cooperate to establish an educational system that adequately prepares dental hygiene practitioners.

Most dental hygiene educators would also agree that post-certificate programs will continue to provide practicing dental hygienists with an opportunity to develop their professional skills. Post-certificate programs may simply provide a transitional and interim step in the evolution of our education system. However, they will be the critical link in that system.

What I will describe is a method for encouraging educational institutions to articulate using cooperative agreements. The system I describe establishes these agreements between basic and post-certificate dental hygiene programs. It is the cooperation, and the system employed to gain it, that is most important in this discussion. The systems approach is applicable to all the articulation strategies that we are considering.

I have also been asked to describe the post-certificate program at Thomas Jefferson University, since we have begun to develop a curriculum that addresses the six future roles for dental hygienists. Some of our innovations, both in curriculum and articulation, could easily be employed in other settings.

Why We Choose the Systems Approach

We used the systems approach, with its emphasis on relationships to develop cooperative agreements between our post-certificate program and six basic dental hygiene programs. These agreements were not intended to represent formal or legal articulations. They primarily serve as communication and advising tools. Because they imply understanding rather than legal commitment, they are easily implemented and easily modified. Their strength is in their flexibility.

1. Setting Goals

A key element of the systems approach is the establishment and understanding of common goals. The two primary goals for our cooperative agreements were:

- *To provide an avenue for basic dental hygiene program graduates to acquire the bachelor of science degree in dental hygiene, rather than another discipline.
- *To facilitate student recruitment for both the basic and the post-certificate programs.

2. Identifying The Individuals and Groups Who Made Up the System

Once the goals of the cooperative agreements between dental hygiene programs were established, it was necessary to identify the components of the system. Components were individuals or groups, formal or informal, permanent or transitional, who would be affected by the agreements. The components of the system would vary from institution to institution, but would include:

Consumers

Dental hygiene program students and graduates who would transfer credits from one program to another.

Dental hygiene program directors.

Individuals at institutions who were responsible for monitoring the cooperative agreements.

Dental hygiene faculty who would serve as advisors for students at each institution.

Registrars

Admissions officers.

Financial aid officers.

Senior school or college officials.

Support staff and secretaries.

Governing boards who must ensure that institutional missions are met.

Coordinating agencies (state and regional).

Persons who write catalog copy and publications.

Persons providing technological and data support.

The college or university legal counsel.

When setting up these agreements, we had to examine each of these components separately. Individuals and groups must be allowed to work their own way, and the way that they will work together must be reviewed.

Developing the Agreements

1. Assigning the Responsibility

One of the first steps in establishing cooperative agreements is to identify an individual to serve as coordinator. This person should have:

A working knowledge of the activities that take place in the admissions, financial aid and registrar's offices.

Experience in transcript analysis for community and four-year colleges.

Experience with the semester and quarter credit system.

A willingness to travel.

Experience with transfer students and their issues.

And that most highly prized of all academic treasures . . . ,
release time to work on the cooperative agreements.

2. Selecting Schools

We initially sought to set up agreements with institutions that were close to Thomas Jefferson University, since we thought that this would facilitate communication. However, geographic barriers really would not present a problem, since communication between the cooperating institutions is not contingent on proximity.

3. Internal Communication

Admissions Office

Before contacting any dental hygiene program, the Admissions Office at Thomas Jefferson University reviewed drafts of materials to be sent to dental hygiene program directors, and a list of those school that would

be contacted. We hoped that by contacting the Admissions staff early in the process, we could identify any potential areas of conflict due to:

- *Previous commitments to institutions that would supersede a cooperative agreement.

- *Problems with language that might later be construed as promises, where none were intended.

In addition, we hoped that the Admissions Office's experience in institutional marketing might enable us to identify concepts that would encourage other institutions to participate in cooperative agreements with us.

The Director of Admissions, and all professional staff who deal routinely with dental hygiene admissions were asked to review initial contact materials. In addition, the schools to be contacted were discussed, so that the professional admissions staff might have an opportunity to identify any institutions where transfer of credits had traditionally been a problem, or where an institutional officer at that school could be counted on to be helpful.

The Registrar

In hindsight, these materials should have been shared with the University's Registrar, who reviews and evaluates all incoming transcripts and can help identify programs where course transfer will require special attention. For example, there are colleges in our region where Pass/Fail is used to describe clinical achievement, or a six-point grading scale is employed. These would not preclude a cooperative agreement with those institutions, but knowing about them in advance would help us to identify the amount of time and expertise necessary to set one into place.

College Officials

Finally, before any materials are distributed, it was important to share them, and the list of institutions to be contacted with the College and University's senior officers. Although unlikely, there may be political constraints that would affect cooperative agreements between institutions. These could be understood but not published, and present an embarrassing situation for the unwary and uninformed. Again, these constraints do not preclude cooperative agreements, but they could affect the ease with which they are implemented.

4. External Communication: Initial Contact with the Dental Hygiene Program Directors

Finally, dental hygiene program directors were asked to indicate their interest in establishing a cooperative agreement with our post-certificate program. In this letter, the purpose of cooperative agreements and benefits, both to their basic dental hygiene program and

institution, and the Post-Certificate Program were identified. The primary emphasis was one of cooperation in times of declining enrollments and limited resources.

Writing the Agreements

Dental hygiene program directors who were interested in establishing an agreement were asked to forward copies of their catalogs and other descriptive materials. We used these to develop the first draft of the cooperative agreement. Although we tailored each agreement to each cooperating institution, certain information was included in all the documents.

I would strongly encourage the person responsible for setting up the agreements to develop the skills necessary, or enlist the assistance of someone who has them, to perform basic word processing functions on a personal computer. With the assistance of a word processing package, generating, editing, and revising cooperative agreements became an easy task rather than a time consuming chore. We currently use an IBM PC XT and the Microsoft Word Processing Package, and find them to be very satisfactory.

We created an initial computer file that contained all of the components of a cooperative agreement. The file was recalled, and the specific information for a dental hygiene program was inserted, revised, and reviewed to create a file for that institution.

Specific Components of the Cooperative Agreements

1. Purpose and Introduction

This section described the purpose and goals of the agreement, and listed all the cooperating institutions and their roles.

2. Curriculum Analysis

This section was divided into three components:

*Distribution requirements for the Bachelor of Science Degree in Dental Hygiene from Jefferson.

*The extent to which a graduate of the dental hygiene program from a cooperating institution had satisfied these requirements.

*A summary of the course work a graduate needed to complete to obtain a baccalaureate degree.

For example, Thomas Jefferson University requires that all students complete eight semester hours of physical sciences as a distribution requirement. Courses that may be used to satisfy the physical sciences requirement include chemistry, physics, physical science, and geology. If all students from a cooperating institution have completed Chemistry 101, Introduction to Chemistry for the Allied Health

Sciences, (four semester credits) in their basic dental hygiene program, they will still need to complete four semester hours of course work in physical sciences to satisfy distribution requirements.

Additional requirements, including minimum grade-point-average for course transfer, and minimal residency requirements, were included in the section on curriculum.

It was important to include a statement in the cooperative agreements that the catalogs of both institutions should be reviewed for additional information. The college or university's catalog does constitute a legal contractual agreement with students. Therefore, issues that were not addressed in the cooperative agreement are described in the catalog.

3. Admissions Procedures

The cooperative agreements did not supersede the admissions processes of the University. They did clarify for students in basic dental hygiene programs how curricula articulate, where they needed additional credits, and the process for applying for admission to Thomas Jefferson University. The cooperative agreements did not promise that a specific number of spaces will be reserved for students, as in a quota.

The agreements specified that graduates from the cooperating institutions must present a cumulative grade point average of 2.75 and recommendations from the faculty. These were consistent with admissions procedures for applicants who have not graduated from a program where a cooperative agreement is in place. Students who do not have a 2.75 grade-point-average can apply, and their credentials are considered individually.

The method that faculty at cooperating institutions used to recommend students to Jefferson's program was not specified. Some dental hygiene faculties have chosen to recommend students individually, while others decided to recommend by consensus.

Students must submit evidence of completion of the National Dental Hygiene Board Examination, evidence of licensure in one state, and final transcripts.

4. Process for Revision

Methods for revising the agreement and for discontinuing it were described. Basically, revisions occur annually, in response to curricular changes in either program. If one institution determined to discontinue the agreement, a six-month notice in writing with appropriate rationale is requested.

5. Student Materials

A summary of the curriculum, course transfers, and admissions processes was included for distribution to students. In addition, a

semester-by-semester schedule of the students' program after admission to Jefferson, on both a full-time and part-time basis was developed.

Reviewing, Approving and Implementing the Cooperative Agreement

After the first draft of the agreement was completed, it was reviewed for accuracy and clarity by individuals at both institutions, including:

- The programs' directors and dental hygiene faculty

- Admissions officers

- Registrars

- Institutional officers

- Students

The legal ramifications of the document should also be examined by the college's legal counsel.

If the agreement is to be implemented in a regional or state system, it should be reviewed by the appropriate individuals from those agencies.

This may seem like a great many individuals to consult. However, the rewards of getting their feedback prior to implementing the agreement will be enormous amounts of time saved in revision and explanation.

The input gathered from these sources was used to develop a final cooperative agreement. This agreement was forwarded and signed by the appropriate university officials. Currently, our agreements are signed by the program directors, the Deans of the College or School, and senior university officers, when necessary.

A final copy of the cooperative agreement should be available to anyone who potentially would need that information. The cooperative agreements are not intended to gather dust in files; rather, they are to be working documents used by advisors, faculty, and those involved in student personnel work.

I have discussed the formulation of the cooperative agreements using the systems approach. I would like to conclude my presentation with a discussion of the post-certificate program, and some of the inroads we have made into the preparation of our students for a future of dental hygiene practice.

Students as Consumers of the Educational Process

As we redefine dental hygiene education, it is essential to keep in mind that those individuals most greatly affected by these decisions will be the public, and those most immediately affected will be our student-public. We must examine the impact of articulation on our dental hygiene students if we are requiring them to become "academically mobile."

As a matter of fact, cooperative agreements such as these may create a new type of dental hygiene student who enters one institution with the ambition of completing the baccalaureate degree at another. There is great potential for confusing or losing these "academic gypsies."

We must also provide for our students a bridge between concrete methods for dealing with information and the abstract models required for the future roles.

All of us in dental hygiene education agree that it is important to educate our students to be critical thinkers, to apply theoretical knowledge to practical situations, to exercise professional judgement, and to support these decisions with rationale. Unfortunately, we also must agree that the education that prepares a dental hygienist to fulfill the clinical role of today is often technically based, and promotes a great deal of memorization.

One way to prepare our dental hygiene students for future roles is to focus on the development of critical thinking skills in their professional courses. We should place greater emphasis on problem solving. Dental hygiene students should be encouraged to focus on the social, economic, and political context of their professional activities. As dental hygiene faculty, we should emphasize the interpersonal, affective, and other noncognitive aspects of their professional development. Perhaps this emphasis would result in the dental hygiene professional we envision for the future.

We have tried to address this need for curricular revision in our post-certificate program curriculum. For example, a large portion of the curriculum is centered around the students' development of personal learning contracts. Most educators agree that the use of this strategy promotes the development of skills essential for lifelong learning. We've also found it helpful in breaking that learned behavior--the "just tell me what to do and I'll do it effectively and expediently" approach--that our dental hygiene students acquire during their basic education. Learning contracts return the responsibility for learning to the students.

We've also structured our courses around the principle of resource and research skills development rather than memorization and categorization. For example, in our courses for the specialization in Hospital Dental Hygiene, students develop the skills essential for working with special patient populations in hospitals and institutions. But they do not have lectures on topics such as oncology patients, and the pharmacology of chemotherapy. What they do learn is how to develop resources. They learn how to seek out nurses, physicians, hospital administrators, patients, pharmacologists, the Index Medicus, and the Index to Nursing Literature. We know that commonly prescribed medications will change. However, the skills necessary to learn about the provision of care for special patients will be useful for many years to come. We believe that this approach is critical to developing dental hygienists who can succeed in a variety of patient care environments.

Preparation for the Six Future Roles

As a faculty, we have made a commitment to preparing the post-certificate students for the future of dental hygiene practice, and the six roles envisioned by ADHA. We have embarked on a series of curricular revisions, and we are finding the outcomes far exceed our expectations.

We have devoted two courses and five semester hours of coursework to the development of skills related to the future roles.

One assumption that we have made is that the dental hygienist who enters a post-certificate program has spent at least two years developing in the clinical role as a basic dental hygiene student and some time after that in private practice. Using the description of the clinical role developed by ADHA at previous Futures' Workshops, we get them to examine their current knowledge and skills and to determine how they will need to develop to fulfill the clinical role we envision for the future. They design a clinical learning contract, describing how they will acquire the skills and knowledge they need to fulfill this clinical role, and how they will determine when they have satisfied their educational needs.

After this practice with the clinical role, we help them assess their ability to fulfill the five other future roles. We invite guest speakers to describe their vision of how the dental hygienist of the future will carry out these roles and assist the students to develop learning activities that give them the opportunity to act as consumer advocates, managers, educators, researchers, and change agents. After they have completed their learning contracts, students again conduct a self assessment of their preparation for each role. They develop a plan for acquiring the knowledge and skills they will need in the future.

We believe that this curriculum approach encourages lifelong learning and prepares these students to be critical thinkers. We hope that it begins to prepare the multicompetencied dental hygiene professional we have described in the "Futures" workshops.

Problems and Outcomes

Our experiences with cooperative agreements, established with a systems approach, have been very positive.

We have found dental hygiene programs in community colleges very willing to set up these agreements. The cooperative agreements promote understanding between our institution at the program and institutional level. In addition, they create an atmosphere of collaboration, rather than competition.

Student feedback has been very positive. They like knowing where they will complete their bachelor's degree, and how long it will take to

finish their education. They also value the sense of continuity created when advanced education builds upon previously acquired competencies and skills.

One problem created by the cooperative agreements was the small mountain of paperwork they generated when they were submitted for review. Simultaneous development of several cooperative agreements translated into a sort of "academic pandemonium," with feedback coming from all sources. A carefully planned, sequential development of cooperative agreements would be more desirable, especially since the Dental Hygiene Department was creating extra work for other divisions within the university, such as the Admissions and Registrar's Offices.

This year is the first year we have had cooperative agreements in place. In all likelihood, next year at this time, we would be able to generate a much longer list of problems. I also feel that we could itemize twice as many benefits.

Summary

I have described a systems method for developing cooperative agreements between dental hygiene institutions, and some curricular innovations that begin to address the preparation of dental hygienists for the future.

The agreements I described provided an avenue for the graduate of basic dental hygiene program to complete the Bachelor of Science degree in dental hygiene in the post-certificate program. However, the articulation method used, the systems approach, could be applied to a variety of curricular configurations.

The systems approach focuses on relationships between individuals and groups. For this reason, it is a very useful tool in establishing cooperative agreements between dental hygiene programs. These agreements enable dental hygienists to complete the baccalaureate degree through institutional cooperation, and to prepare for the future of dental hygiene practice.

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INTRODUCTION: DEBORAH MILLER, RDH, MS

Cheryl Westphal, RDH, MS

A specter of declining enrollment has been walking the corridors of our educational institutions. Some of us could tell tales of firsthand encounters. For others, this specter is just another member of a ghoulish cast of characters wreaking havoc on our educational system. For educators, hygiene educators in particular, it has been a worrisome phenomenon.

A recent article in the Chronicle Of Higher Education cited projections by the U.S. Department of Education that the number of traditional college-age students will remain relatively stable and that older, nontraditional students are taking up the slack in regions experiencing declines. Their projection of a leveling off and shifting in type of student is a welcome relief to a previously gloomy picture. But don't pop the champagne, we are not yet out of the woods. To be progressive thinkers, we must reframe our approach to the issue of recruitment.

There are signs that this is happening. The February 18th article in the Chronicle of Higher Education entitled "Enrollment Management," describes the efforts by several institutions to implement strategies to improve recruitment, enrollment and retention. If you read between the lines you will discover that educational institutions are trying to market themselves by improving their ability to meet student needs. For people to seek a service, they must want that service. Therefore your strategies must address the needs of the person consuming your product. If there were a bottom line to all of this, it might read: You will attract students if you meet their needs.

Can this work for institutions of higher learning? The possibilities may only be limited by our ability to be creative. It is crucial that we explore the unusual concept, follow the innovative path, expand our acceptance of what is and what can be.

We have the opportunity to start that process today. We need to ask the question, "If articulation improves our ability to meet student needs, is this a potential strategy for recruitment?"

Our next speaker, Deborah Miller, will address the relationship between articulation and recruitment. Currently an assistant professor at Idaho State University, she received her bachelor's and master's degrees from the University of Iowa. Ms. Miller serves on a variety of university, college and department committees that address student, recruitment, programmatic, and institutional concerns.

In the scramble to recruit the brightest and the best, institutions will achieve their "market position" based on an ability to incorporate innovative strategies that meet student needs. Can articulation be a resource for the future? To speak to this question, it is my pleasure to introduce Deborah Miller.

RECRUITMENT THROUGH ARTICULATION

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We come to this meeting with similarities and differences; we represent diverse geographic regions and contrasting types of programs--but one thing we all have in common is the need for effective student recruitment strategies. Articulation can be a recruitment tool. Student recruitment is a long range prospect--an investment in the future. Most recruitment activities do not have immediate results. Articulation can augment recruitment because the goals of articulation are compatible with the goals of recruitment. Recruitment is a matter of matching the needs of the student with the resources of an institution or program. Articulation offers the potential for resource expansion within and between institutions and their academic programs. Thus, articulation serves as a resource for the future.

Characteristics of college students are changing. Therefore, recruitment efforts must be expanded to include prospective students beyond the scope of high schools. The population of high school students is declining. The baby boom is over. There are two areas in which to look for new, potential recruits; junior high students and the nontraditional student. Research in career development by such people as Donald Super and Eli Ginzberg indicates that students start considering career options much younger than once thought.^{1,2} It is time to foster recruitment at the junior high level. An example of such an effort is that colleges are now offering scholarships to academically talented students while they are still in junior high. Interest and access must also be nurtured in students that are older, more mature, and nontraditional. These students will usually be less mobile and require more flexibility in the programs they attend. High schools were once the primary place of recruitment. Now, junior high schools and post high school areas should also be primary sources.

Institutions of higher learning are changing also. Less money is available for education today and the burden of fiscal accountability is increasing. Dental hygiene programs are expensive in terms of dollars per student necessary for this specialized education. The time is ripe for innovative methods of resource sharing. Sharing resources, including students, is a means of maintaining quality programs with increasingly limited funding. Because the competition is high for students, there are only two choices for institutions and dental hygiene programs in particular--competition or cooperation. If the choice is competition, the result is sharper institutional competition for a shrinking student pool. However, the choice to cooperate can result in sharing students, and therefore, increasing the student pool. As Dr. Ernest Boyer, former U.S. Commissioner of Education said, "The need is to cooperate, not because it is the gentlemanly thing to do, but rather because it is the urgent thing to do."³ Articulation is a major component within the cooperation choice, and inherent in its meaning is giving and receiving. The use of articulation is

advantageous to students and institutions because its basic goals are to (1) increase continuity, (2) increase cost containment, and (3) increase quality in the educational process.⁴

To achieve the recruitment goal of matching student needs with institutional or program resources, the student needs must be identified. Research by Bross and Smugar in the area of student factors involved in college choice, identified five major factors influential in student's choice of institution:⁵

(1) employment opportunities, (2) quality of academic programs, (3) educational opportunities after graduation, (4) teaching reputation, and (5) cost. Each of these areas can be augmented by articulation.

Employment opportunities can be enhanced by creating new options for career mobility. This can be accomplished by providing educational opportunities beyond the traditional dental hygiene preparation for private practice. By providing advanced dental hygiene courses in medical history interpretation and medical emergency preparation, barriers to oral health care, innovative health care delivery systems, and research career options for dental hygienists can be expanded. By expanding the employment opportunities we may impact on the applicant pool because the educational program becomes more attractive to potential students. Coursework or areas of expertise can be shared between institutions to expand the employment opportunities of the students. Four-year institutions have the opportunity to provide students with expertise in such areas as advanced clinical procedures, hospital dental hygiene, or health delivery to special needs populations. Because it is no longer possible for an institution to be all things to all people, through collaboration and articulation, institutions can share areas of expertise without having their resources spread too thin. Students can attend one institution for the majority of their education and then change to another, for instance in their fourth year, for career tracking in the student's interest area. By sharing students and areas of expertise, institutions can provide additional career options to students while maintaining costs, and to iterate, employment opportunities and cost are both factors identified as influencing a student's choice of an institution.

Quality of academic programs can be enhanced by expanding the programs' educational opportunities through resource sharing. Existing resources in either the university or adjacent institutions can be utilized rather than duplicated. Each institution has unique strengths and students can gain access to educational resources otherwise unavailable. Students can have educational options that transcend the individual campuses. An example of sharing facilities and faculty can be exemplified by satellite campuses created by nursing departments in Idaho. Idaho State University provides faculty to the Boise State University Nursing Department for a master's degree option and to a junior college for a baccalaureate degree option on their campuses. The receiving institutions benefit by the ability to recruit additional students by providing expanded career options and by serving the needs of community health professionals desiring advancement. The providing university benefits by additional FTEs and student tuition. The

quality of academic programs is affected by curriculum. The Kentucky Allied Health Project reported that curriculum revisions as a direct result of the articulation process strengthened the individual departments involved in formulating articulation agreements.⁶ Since quality is a concern of students in their choice of institution, these departments would most likely be more attractive to students.

Educational opportunities after graduation can be profoundly affected by articulation between two-year and four-year institutions. Students can graduate with a baccalaureate degree in dental hygiene, which qualifies them as potential applicants for master's degree programs. Graduate courses in health care administration, dental hygiene clinic, education, research, health promotion, and the social sciences are available for the continual education of the student. Articulation can also affect educational opportunities before graduation by eliminating unnecessary duplication or artificially imposed barriers that inhibit the ability or motivation of the individuals involved. Transfer barriers between institutions can be removed by using such mechanisms as common course titling, common course numbering, and electronic transfer. Beyond transfer barriers, extending the dental hygiene education can require a transfer from a two-year institution to a four-year institution, which usually involves a credit transfer limit of approximately 70 semester credits. If a student completes the basic dental hygiene curriculum at a two-year institution, that student will have an excess of 70 credit hours. When transferring to complete a baccalaureate degree, those excess credits are not counted for fulfillment of the degree requirements. This barrier must be removed if we are to be successful in recruitment through articulation. Articulation is one mechanism for reducing or eliminating transfer barriers thereby making programs more attractive to potential students. Possibilities include:

- (1) simultaneous enrollment in the two-year and four-year institutions,
- (2) the opportunity to challenge courses in the four-year institution dental hygiene department for upper division university credit, or (3) granting upper division credit for courses taken at the two-year institution.

This option differs from the post-certificate program as we know it today because it affords the opportunity for students to complete a bachelor of science degree in less time with less cost. It also can serve as a recruitment strategy for both programs involved, since educational opportunities are expanded and student referral is likely.

Teaching reputations can be enhanced through articulation by cooperation. By increasing communication and cooperation between institutions and dental hygiene departments, there should be decreased time spent exalting one's own program and more time spent in joint recruiting efforts. For example, shopping malls are a place to contact nontraditional students, so a group of dental hygiene programs could display recruitment slides or videos and perhaps include students for community health projects. Collaborative research efforts, including sharing research funding, between faculty in institutions of geographic proximity can enhance teaching reputation and increase institutional exposure. Reputations are influenced by public relations. Developing

strong positive relationships with advisors and counselors at all levels of education can also enhance one's reputation and increase counselors' awareness and interest, therefore presenting a positive attitude to potential students.

The final factor identified by students in their choice of institution is cost. The cost containment benefits from articulation agreements can be passed on to the student through cost maintenance or reduction. Inherent in cost containment is resource utilization. One way to use resources is to share; share with institutions within your geographic region; share all resources, not just facilities, but students, equipment, coursework and curriculum, staff, faculty, land, buildings, computers, library services, industry, and the community at large. The geographic location of an institution, as well as the size of the community, provide unique opportunities for students. An urban-rural linkage can allow for career expansion for both geographic localities.¹⁰ The urban institution involved in the articulation agreement can provide opportunities for student exposure to outreach programs such as migrant workers programs, Indian reservations, or home health. Students can have the advantage of additional career options without the additional costs of leaving their home environment for extensive periods of time. In terms of recruitment, institutions can offer students opportunities beyond the individual campus resources while maintaining cost. Cooperative ventures can also result in increased funding for the institutions. The state of Illinois, under the Higher Education Cooperative Act, appropriates several hundred thousand dollars annually for joint programs.¹¹ Students can further benefit financially through reciprocal support between states when participating institutions are located in different states. For example, Idaho and Utah legislatures have approved a certain number of fee waivers for students in the neighboring state, thus requiring those students to pay only in-state tuition. This is a great recruitment tool. Another example is the offering of scholarships designated specifically for transfer students or out-of-state students. A place to look for funding for scholarships is dental or dental hygiene districts.

In addition to these five factors previously identified by students, as educators we must be concerned for academic recognition of achievement by students. Data presented by Dona Wayman in 1984 reports that 67% of associate/certificate programs require students to complete college credit beyond the two years required for an associate degree.¹² Research by Kay Mescher reported that by 1981-82, 43% of the students entering dental hygiene programs had at least two years of previous college and 29% had one year of college. The students receive no additional academic recognition, and may receive a certificate in dental hygiene for three years of college. Then, if students want to continue their education and receive a baccalaureate degree they must enter a university with junior status and attend an additional two years of college. This is not academic recognition for achievement, and as an educator, I find this difficult to justify.

Articulation has the potential to change this situation. I will now present four projective models or options where articulation can

facilitate academic recognition for students and increase recruitment opportunities for the dental hygiene programs involved.

Option 1--involves an articulation agreement between a community college with a dental hygiene program and a university offering a baccalaureate degree in dental hygiene.

One year of community college: The student takes one year of prerequisite courses at the community college level including science, math, English, and humanities.

Two years of dental hygiene: The student then stays at the community college and takes the traditional two-year dental hygiene curriculum. However, through articulation in the second year of dental hygiene (or third year of college) the student will receive upper division credit at the university in which the articulation was established. This is not only feasible, but it has already been demonstrated by articulation in existence between Sheridan College (a community college) and the University of Wyoming.

One year of university: In the fourth year the student attends the university for advanced hygiene coursework and upper division liberal arts courses. At the end of four years, the student receives a Bachelor of Science degree in dental hygiene.

I referred to this as a projective model and cited Sheridan College and University of Wyoming as an example because the articulation in this instance is between a community college with a dental hygiene program and a university without a dental hygiene program. I project this is also possible with a community college and university both having dental hygiene programs. In this case not only will the student benefit by these factors previously identified as influential in student choice, but the institutions involved will benefit through recruitment opportunities. The more you can offer prospective students, the easier recruitment becomes. Also, competition for the same student is reduced since both institutions share that same student.

Recruitment is sustained through communication. Former graduates should be good recruitment contacts. Graduates of a program similar to Option 1 have the advantage of attending two institutions. Efforts toward graduate public relations can be combined to benefit both institutions: for instance, sending a joint newsletter or having alumni host social gatherings for interested high school students and have access to slide or videotape recruitment series to show in school career or health classes. By improved communication between institutions, cooperative ventures of recruitment in high schools and junior high schools are feasible with less financial outlay for both. For a successful articulation agreement exemplified by Option 1, there are keys to success:

1. An articulation agreement for upper division credit in the student's third year of college or second year of dental hygiene.
2. Communication between dental hygiene departments in the two

- institutions for purposes of curriculum compatibility.
3. Financial waivers if the two institutions are in different states.
 4. Joint recruitment ventures.

Option 2--involves an articulation agreement between a community or junior college without a dental hygiene program and a university with a dental hygiene program. This is a typical two-plus-two program with which many of you may be familiar, but articulation and recruitment strategies can be enhanced as portrayed in this option.

Two years of community college: Students attend the community college for two years and receive an Associate of Arts or Associate of Science degree while fulfilling the admission requirements of the dental hygiene department at the university.

Two years of university for dental hygiene education: The students enter the university with junior status and complete their dental hygiene education in the next two years. The students benefit by staying in their home environment at a school without a dental hygiene program, yet still having the option of receiving a Bachelor of Science in dental hygiene in four years.

For a successful articulation agreement exemplified by Option 2, there are keys to success:

1. An articulation agreement between institutions guaranteeing easy transfer of courses for students.
2. Personal communication between the dental hygiene department in the university and the identified advisors at the community college.
3. Dental hygiene prerequisite courses listed in the community college catalog as a pre-dental hygiene major, so students are aware that an easy transition to dental hygiene at the university is available.
4. Contact, personal if possible, with the students throughout the first two years of college including invitations to university recruitment days, functions, etc.

In Option 2, recruitment is directly affected by communication between institutions. It also aids manpower distribution by providing education in geographic areas that need health care professionals and services where there may not be a dental hygiene program.

Option 3 - involves an articulation agreement between a community college with a dental hygiene program and a university with a dental hygiene program; however, the student receives all four years of education at the community or junior college.

One year of community college: The student's first year at the community college is primarily involved with prerequisite courses and general education requirements.

Two years of community college: The student spends the next two years within the dental hygiene department with upper division credit for the third year of college granted from the university where the articulation agreement exists.

One year of community college: In the fourth year the student will take advanced dental hygiene and upper division liberal arts at the community college, but taught by faculty with appointments to the university so students can receive a Bachelor of Science degree in dental hygiene at the end of four years.

This option illustrates the concept of extending university education beyond the boundaries of the university campus. It exemplifies the concept of resource sharing in the cooperation between institutions. This option allows students to receive all four years in their home environment through the establishment of satellite campuses. The older, less flexible student can benefit from taking classes at an institution near their home. In terms of recruitment, it increases access to baccalaureate education in geographic locations where universities are scarce.

The keys to success for Option 3 are:

1. An articulation agreement for upper division credit in the student's third year of college or second year of dental hygiene.
2. Cooperative ventures in faculty sharing and faculty appointments.
3. Flexibility at the community college for resource sharing at all student and faculty levels.
4. Salary, tuition, and FTE sharing between institutions.

Option 4- In the previous three options, I have illustrated articulation possibilities utilizing existing mechanisms. This fourth option provides a more futuristic view presenting a four-year integrated curriculum, because it breaks down the artificial barriers usually associated with dental hygiene curriculum. In other words the dental hygiene and the liberal arts are interspersed throughout the four-year education.

This can be accomplished at one institution, or more than one, utilizing simultaneous enrollment between institutions. A four-year institution can accomplish this goal or a two-year institution articulated with a four-year can as well, particularly with the use of telecommunications or satellite faculty.

The first year consists of lower division science, liberal arts and introductory dental hygiene classes. The second year continues the prerequisite coursework, but becomes more focused on dental hygiene including clinic. The third year's major focus is dental hygiene courses followed by a fourth year of behavioral sciences, social sciences and advanced dental hygiene to allow more career options and provide a clearer direction and increased relevancy in upper division courses. This type of curriculum creates the potential for students to

be exposed to assessment, implementation, evaluation of health promotion programs, health delivery systems, computer technology and applications, legislative and political processes, research, motivational psychology, and management and organization of oral health promotion. It opens the doors to career expansion and career mobility which were cited earlier as attractive options to prospective students.

There are increased possibilities in recruiting academically talented high school students into dental hygiene once again. Through early identification of junior high and high school students who are interested in dental hygiene, coupled with personal liaison between college and high school advisors, students can be influenced to take an adequate amount of science and math courses early in their high school years. Articulation between a high school and a college is possible, allowing a limited number of high school seniors to concurrently take their sciences at the college level for college credit. This would display our commitment to students and career development in an ever changing health care environment. By offering college credit to high school students, it could be possible to finish the required courses for a Bachelor of Science in dental hygiene sooner and expand the options of career exploration and tracking in their fourth year of college.

Through the use of articulation and resource sharing, dental hygiene programs can offer additional career options with academic recognition for achievement without additional financial burdens for the student. As evidenced through these models, innovative recruitment strategies can be developed. Incoming students would have a more accurate picture of total educational opportunities available. Not only does the quality of education increase for the student, the quality of the graduate increases for society. However, with rewards there are responsibilities.

For articulation and recruitment to be successful it requires a sense of commitment, compromise and willingness to subordinate one's specific interests for a larger objective: a sense of commitment to students from all levels of higher education and all types of institutions rather than faculties clinging to professional and personal vested interests. It also requires a willingness to work with administrators within your institution to develop articulation agreements and recruitment strategies shaped according to the needs and resources particular to your region. It involves a time commitment to recruitment including developing recruitment packages illustrating articulation agreements, organizing work experience or exposure to dental hygiene at all educational levels, developing personal relationships with advisors and counselors and the early identification and follow up of interested students. It also involves sharing information about successful articulation agreements and recruitment practices among ourselves to the benefit of all dental hygiene programs. We can go farther together than alone, and in the end everyone will win.

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INTRODUCTION: ELIZABETH PELTON, RDH, MS

Connie Tussing, RDH, MBA
ADHA President

As the American Dental Hygienists' Association continues its efforts to address future educational and practice issues, we cannot forget the concerns that face you today as you practice and teach. We are well aware of the difficulties encountered by some of you in recruiting candidates into dental hygiene programs. And on the other hand, of practitioner concerns with regard to competence assurance issues of colleagues.

The American Dental Hygienists' Association has determined that career recruitment should be addressed by all of us who have a stake in the future. The next workshop in our series will specifically consider this critical issue. The dates for the workshop will be announced in late summer.

Further, a subcommittee has been appointed for the expressed purpose of planning ADHA's role in this national effort. Shortly, you will be introduced to the first step we have taken in this endeavor.

ADHA is here to assist and support your goals for educating the finest students possible and for assimilating those graduates into our practice community. You will be called upon for advice and the sharing of resources. Please join us as we prepare today for the future.

At this time, I would like to introduce you to the chairman of the Subcommittee on Career Recruitment. She received a bachelor of science degree in Dental Hygiene and a master of science degree in Dental Hygiene Education/Administration from the University of Iowa. She is an Associate Professor in the Department of Dental Hygiene at the University of Iowa.

Her previous areas of research include a "Comprehensive Study on Baccalaureate Dental Hygiene Graduates" and "Dental Hygiene Manpower."

She is currently involved in several projects including "A Pilot Study to Assess the Effectiveness of Dental Hygienists as Referral Agents in Iowa," and "The Role of Professional Associations as Facilitators of Effective Volunteerism."

In addition to her research activities, she has published articles addressing a variety of dental hygiene issues, including "Volunteerism: A Means of Demonstrating New Roles for Dental Hygienists", and "Baccalaureate Dental Hygiene Graduates' Perceptions of Community Dental Health Employment". Please welcome Ms. Beth Pelton.

RECRUITMENT LUNCHEON ADDRESS

Elizabeth Pelton, RDH, MS
Associate Professor, Department of Dental Hygiene
The University of Iowa
Iowa City, Iowa

In a previous workshop we established that the dental hygienist shall be a knowledge worker. During a subsequent workshop we determined the future roles in which the dental hygienist knowledge worker shall function. Our curricula will change as we strive to prepare this knowledge worker to function in these roles. We have established that four years of dental hygiene education shall be the entry level into our profession. We now are discussing articulation mechanisms that can facilitate the realization of our objectives.

While we address these issues we also must address recruitment. Once we define the skills and abilities of this knowledge worker dental hygienist, we must then look at the characteristics of likely candidates for our profession. It should not be surprising to find that we will be looking for a different individual from the one we look for today. We need to determine the types of personal characteristics we want in dental hygienists. What type of market niche do we want? Who will be interested in the social and behavioral sciences? In communication skills, counseling, conflict management, health promotion? Who will be interested in being a health advocate? How can we attract and retain the knowledge worker to dental hygiene? What types of student customers will be interested in us? Where are these student customers?

Our recruitment efforts must be re-evaluated. Traditionally we have depended on others to recruit many students into dental hygiene. Now, those other groups view where we are and where we are going quite differently than we view where we are and where we are going. We should look toward other people that could help "sell" dental hygiene as we see it. Junior high and high school teachers, early college year faculty from disciplines such as sociology, psychology, the humanities, mentors of the student customer...these people are more appropriate dental hygiene recruiters than the dentist. Still, the only ones who truly will "sell" dental hygiene to the student customer are dental hygienists. We must all be actively involved in dental hygiene recruitment. Dental hygiene educators, practitioners and alumni must be involved.

Gone are the days when recruitment activities could consist of high school career days and brochures, alone. Educational recruitment is a highly competitive business. One author even has termed recruitment as a "body snatching trade."

As our profession evolves, so must our recruitment efforts. As we clarify the focus of dental hygiene, as we emphasize the dental hygienist as a knowledge worker, as we standardize curricular length, we must also address recruitment in its broadest perspective. We need

to re-examine our existing recruitment resources and collaborate on future recruitment resources.

President Tussing has recognized that there is a need for us to plan strategically for recruitment on a national level. She has appointed a Subcommittee on Career Recruitment. The Subcommittee is an arm of the Council on Educational Services and Research and will function in concert with that Council. The Subcommittee's task is to outline a prioritized plan of Association support for educational recruitment.

The Subcommittee is comprised of three dental hygiene educators who represent a variety of educational settings. President Tussing has appointed the following members to the Subcommittee: Kathy Mellor of Forsyth School of Dental Hygiene; Barbara Nelson of Clark County Community College; and Beth Pelton of The University of Iowa.

During this Workshop the Subcommittee met with President Tussing, President-elect Marge Empey, with Linda Hanlon, Chair of the Council on Educational Services and Research, and Cheryl Mounts, Gloria Crawford, and Carla Williams, ADHA Staff. Objectives for the Subcommittee have been drafted and will be transmitted to the Council for review. Upon Council approval, the objectives will be submitted to the ADHA Board of Trustees for consideration. President Tussing, the Council on Educational Services and Research, and ADHA staff are to be commended for their foresight to promote ADHA involvement in recruitment in its broadest perspective.

Under Connie's guidance, a project was implemented to seek funds to begin to respond to the recruitment needs of our profession. Funds were procured from the Proctor & Gamble Oral Health Group. We now present to you a poster that will be disseminated to major libraries and high schools across the country. Each dental hygiene program will receive a poster, as well as liaison groups throughout the nation.

This initial endeavor exemplifies the Association's determination to address dental hygiene recruitment. As an expression of appreciation to you for your participation in this workshop, we are providing each of you with a poster. The poster is of frameable quality. We hope that you will display it in your workplace area.

This luncheon provides us an opportunity to give thought to our current recruitment materials. At your table we would like you to discuss the recruitment activities and materials you have found to be successful as well as those that have not been successful. This is a time to share ideas about recruitment activities can.

We've asked you to bring copies of your recruitment materials to share with those at your table. During lunch ADHA staff members will come to your table. Please give them a copy of each piece you have. This will speed the task of the Subcommittee as we begin to study existing recruitment materials that are used in dental hygiene.

To stimulate thought and discussion, I would like to share with you an example of what can be done with slides, music, and a low budget. You

will see a seven minute showing of dental hygiene students at The University of Iowa. The slides and music are intended to depict experiences and feelings of liberal arts students majoring in dental hygiene--students in all facets, as they constitute an integral part of the academic, social, and cultural environment of a large university.

Advantages of a showing like this are: there is sight, sound, a feeling of movement. Slides can be exchanged, substituted. Other music can be substituted. Once the program is in place, it can be VCR taped for use in schools and private homes.

Disadvantages, as I see them are: This takes many hours of time distributed over many months to produce. For every slide that is selected there are many that are rejected. It is amazing how many telephone poles can grow from people's heads. To some, another disadvantage could be the audio-visual equipment which includes slides, a tape, two projectors, a recorder, dissolving unit, an amplifier and speakers. Let's face it, some of us find the overhead projector to be a challenge. The thought of entering a world of using two projectors at the same time can bring on a wild flash of panic. Still, we need to direct our recruitment techniques toward the generation that watches the video channel.

I hope this example has stimulated thought and will stimulate discussion at your table. Now, let's share our recruitment ideas. Let's exchange how we can modify to make our recruitment activities more effective.

SUMMARY AND CONCLUSIONS

Cheryl Westphal, RDH, MS

When the committee began planning for this workshop it was our hope that not only would the participants work diligently to achieve the stated goals but that all of us would leave expressing the need to foster communication, collaboration and cooperation within the dental hygiene community. It is our feeling, as I trust it is yours, that we have taken that all important first step.

I have had the opportunity to review the work generated from yesterday's small group sessions. You will be encouraged to know that there was a great deal of consistency in the benefits, barriers and tentative outcomes identified. The most effective and positive approach to effect change is to focus on the desired outcome. Let me share a few of the most common outcomes you spoke to yesterday.

Articulation As An Outcome Will Facilitate:

1. Regular communications -- meetings
2. Collaboration on recruitment issues
3. Increased public knowledge regarding the need for care and the utilization of dental hygiene services
4. Faculty exchange
5. The sharing of legislative activities
6. Funding mechanisms
7. Curricular assessment and development
8. The development of programs that meet student needs
9. Greater faculty development
10. The involvement of other communities of interest, including diverse disciplines
11. The establishment of alliances to create more diverse curricula

It is my understanding that action plans have been developed to implement many of these tentative outcomes.

This has been an exciting and fast moving two days. Today, we have new ideas and lots of energy. Once we disperse, how will we sustain our momentum? Where do we go from here?

Consistent with previous workshops, proceedings will be developed and disseminated to participants, education programs, dental hygiene constituents and interested parties.

Although the next workshop is still in conceptual stages we have reason to believe that we will focus on career recruitment issues.

You must know that we have not forgotten the charge of finalizing a curriculum with sufficient skills and knowledge to support the roles and responsibilities identified at workshop II.

It is our intent that this curriculum will be presented at a future education and practice workshop. We understand that time is of the essence as we move forward to meet the needs of a society that is experiencing unrivaled changes.

It has been my pleasure to work with dental hygiene leaders. Clearly our collective efforts will provide the impetus, knowledge and leadership needed to support the process of professionalization.

APPENDIX PROLOGUE

As indicated in the Table of Contents (iii), a compilation of workshop materials is included in Appendices B-G. Information from the small group sessions includes facilitators names, group breakouts, and outcomes from Sessions I and II. Results from the workshop evaluation forms have been synthesized and are reported. Additionally, a map depicting state specific representation of workshop participants and a participant roster are included.

SMALL GROUP AND FACILITATOR ROSTER

JOANN GURENLIAN, FACILITATOR
SOUTHERN REGION
GREEN RECTANGLE

Dr. Joseph Lynch, KY
Teresa Butler, KY
Mary Akerly, MS
Lundee Amos, NC
Linda Edward, FL
Judith Skelton, FL
Lee Weisenborn, FL
Ann Dinius, VA
Constance Kee, VA
Michelle Darby, VA
Mary Alice Gaston, TN
Patricia Littlejohn, TN
Anne Hutcheson, VA

DEBI MCFALL, FACILITATOR
EASTERN REGION
YELLOW RECTANGLE

Linda Kraemer, PA
Joan McClintock, PA
Kathy Mellor, MA
Carolyn Harbourt, NJ
Judith Davidson, ME
Dona Wayman, NY
Anita Cunningham, NY
Ann Goodwin, NY
Kathryn Sielski, NY
Jocelyn Roman, CT
Olga Ibsen, NY
Patricia Jones, WV

BETH PELTON, FACILITATOR
EASTERN REGION
GREEN CIRCLE

Marcia Brand, PA
Linda Hanlon, MA
Kathern Friel, DE
Carolyn Hartnett, NH
Cheryl Metzger, MD
Dianne Bassage, MD
Johanna Odrich, NY
Elizabeth Pitz, NY
Selena James, NY
Roberta Smith, NY
Ilene Biller Karlson, PA
Joellen Lee, ME

DENISE BOWEN, FACILITATOR
WESTERN REGION
YELLOW CIRCLE

Dolores Malvitz, OK
Tricia Moore, AZ
Mary Jane Winters, TX
Donna Barnes, CA
Shea Shannon, CA
Debra Wilson, CA
Glenna Taylor, NM
Karen Demetre, WA
Martha Fales, WA
Susan Clifford, CA

SALLY DECK, FACILITATOR
WESTERN REGION
BLUE RECTANGLE

Susan Marcus, OK
Donna Stach, CO
Anita Herzog, ID
Anna Pattison, CA
Jean Poupard, CA
Deb Miller, ID
Sherry Lemon, OR
Cynthia Garvin, WA
Linda Lowe Coats, WA

JANE FORREST/SHELLY FRITZ, FACILITATOR
WESTERN REGION
BLUE CIRCLE

Janet Shurtz, OK
Carlene Paarmann, ID
Mary Abbott, MT
Myrna Kalman, CA
Karen Wells, CA
Evelyn Hobbs, OR
Barbara Nelson, NV
Peg Ryan, OR
Judy Hartje, WA
Janie Noble, TX
Cheryl Cameron, WA

RUBY MEADOR, FACILITATOR
MIDWEST REGION
ORANGE RECTANGLE

Renee Robertus, MO
Linda Leshner, OH

Sharon Grayden, MN
Sue Janusz, IL
Diane Huntley, KS
Kay Oser, IN
Kurt Truax, AR
Ruthann Peterson, WI
Marianne Hashimi, MI
Beverly McDonald, MI
Recie Pennell, KS

Deborah Carter, MI
Kathy Newell, MN
Chris Simmons
Crystal Fern, NE
Judy Smith
Cindy Brown, AR
IDHA Representative, ID
Susan Sauer, IL

**CAREN BARNES, FACILITATOR
MIDWEST REGION
RED RECTANGLE**

Gwen Hlava, NE
Joan Gill, OH
Trudy Palmateer, OH
Karen Maloney, IL
Nancy Slach, IA
Sarah Turner, IA
Lucy Podruch-Conrad, WI
Theresa Hallowell, MI
Wendy Kershbaum, MI
Maureen Munger, MI
Kay Mescher, IA
Beth Dalley, WI

**SUSAN TOLLE/EMILY CARR HOOD, FACILITATORS
MIDWEST REGION
RED CIRCLE**

Linda Slatterly, MO
Lynnette Lynn-Fraser, OH
Marianne Holt, IL
Julie Janssen, IL
Cynthia Heischmidt, IL
Pam Overman, KS
Sandra Leggett, IA
Nancy McKenney, WI
Jean MacDonald, MI
Wanda Scott, MI
Pam Zarkowski, MI
Jan Wilson, MI

**ELLEN ROGO, FACILITATOR
MIDWEST REGION
GREEN RECTANGLE WITH RED DOT**

Shirley Bensen, IL
Kimberly Benkert, IL
Margaret Biethman, KS

SMALL GROUP SESSION I
GREEN CIRCLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

Recruit qualified students
Consumer involvement/support
Education of other professionals
Employment opportunities
Increase faculty and student resources
Faculty and student exchange
Regional faculty/student workshops
Help in accreditation
Help in legislative issues
Sharing information for institutional change
Facilitate professional growth and development of faculty
Collaborate on research
Cost effectiveness

BARRIERS/OBSTACLES:

State agencies
Dentistry
Attitudes
Applicant pool/lack of recruitment career opportunities
Consumer awareness/support accrediting agencies of two-year programs
Mission/goals of two-year programs

TENTATIVE OUTCOMES:

1. Regional faculty forum at regional student meeting.
2. Policy forum for dental hygiene educators sponsored by ADHA.
3. Sharing of documentation for BS programs and job opportunities.
4. Look into issues of faculty development.
5. Educating other allied health professionals and other dental hygiene educators and practitioners.

SMALL GROUP SESSION I
RED CIRCLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

1. Recruitment
2. Legislative
3. Mutual understanding
4. Less course duplication
5. Utilization of resources
6. Student project curriculum
7. Students have broader world view
8. Develop life-long learners
9. Consumer benefit
 - a. costly
 - b. better access to care
 - c. better quality of care
 - d. humanistic viewpoints
 - e. interpersonal relations
10. Heightened awareness of wellness
11. More career options
12. Easier transfer of credits
13. Networking
14. Stronger professional organization
15. Uniform voice and philosophy
16. More power
17. Better decision making
18. Better utilization of community resources
19. More faculty development
20. Increased mobility
21. More faculty and student incentive to advance

BARRIERS/OBSTACLES:

1. Legislative
2. Costs to develop
3. Geographic - correlation among states
4. Resistance to change
5. Administration
6. Dental community and community-at-large
7. Elitism
8. Turfdom
9. Loss of faculty positions
10. Time, personpower
11. Controversy over career options
12. Networking, lack of identifying appropriate resources
13. Environment, problems with home
14. Previous failures with alliances

15. Apathy
16. Faculty credentials
17. Regional differences and differences between practice acts
18. Lack of autonomy, ie., accreditation
19. Inability to make decisions
20. Potential loss of applicants and conflicting desires of students
21. Financial aid problems
22. Problems with transfer of credits
23. Tuition in-state and out-state/district
24. How to delineate roles
25. Problems with implementing programs in response to practice acts

TENTATIVE OUTCOMES:

1. Develop sources of funding.
2. Increased networking.
3. Development of knowledge through research.
4. Start to take risks.
5. Develop role delineation.
6. Better recognition from legislature and consumers.
7. Alliances with other allied health care professionals.
8. Articulation with universities.
9. Empathy developed within programs.
10. Building pool of resources for articulation.
11. Develop articulation models for others to use.
12. Gain administrative support and involvement.
13. Develop resource/transfer manuals.
14. Educate others about articulation.
15. Develop survey of alliance options.

SMALL GROUP SESSION I
GREEN RECTANGLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

1. Share ideas
2. Reduce stress
3. Reduce isolationism of faculty
4. Share resources
5. Stimulation
6. Burnout
7. Process of "reinventing the wheel"
8. Share workload (recruitment)
9. Regional mobility and flexibility for practitioners
10. Standardization of curriculum
11. Student mobility (program to program)
12. Financial benefits for
 - a. Students (common markets)
 - b. Institutions
13. Benefits or opportunities for practicing hygienists
14. Interaction with other allied health educators
15. Consumers (patient) benefits - awareness, quality awareness
16. Institutional benefits stored resources (faculty exchange and development)
17. Improve access to various student types
18. Job opportunities for graduates

BARRIERS/OBSTACLES:

1. Geographical distance
2. Time
3. Money - faculty, institutions, students
4. Enrollment competition especially as it is tied to finding formulas
5. Turfdom
6. Curricular modification red tape
7. Wide range of institutional levels
8. Resistance to change
9. Lack of communication
10. Individual personalities
11. Lack of faculty participation
 - a. Lack of interest
 - b. Lack of support

- c. Lack of communication
- 12. Politics - government, academic and professional
- 13. Meeting different students' needs and wants
- 14. Practice/supervision issues and differences (state to state)
- 15. Control of accreditation

TENTATIVE OUTCOMES:

- 1. Telecommunications - course exchange, faculty exchange, conferencing, cross registration
- 2. National faculty development - curriculum being developed by AADS
- 3. Satellite campuses
- 4. Transportation networks
- 5. Strengthen professional relationships
- 6. Faculty workshops
- 7. Identify funding sources
- 8. Broaden research capabilities and participation
- 9. Innovations (curricular, etc.)
- 10. Flexibility
- 11. Enrollment/recruitment
- 12. Improved quality of care and access to care
- 13. Strengthen the profession
- 14. Political influence
- 15. Diversify curriculum
- 16. Student exchange programs
- 17. Maximize usefulness of credits/education
- 18. Development of transfer guides
- 19. Student counseling improved

SMALL GROUP SESSION I
BLUE CIRCLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

- Larger recruitment pool
- Sharing resources
- Marketing the profession
- Career retention
- Mobility
- Educational uniformity
- Enhance quality of education
- Better prepared graduates
- More access to the profession
- Time and cost effectiveness
- Recognition of time spent now (3 years)
- Attitude towards BS degree
- Remove first and second class citizen syndrome
- Communication with other health professions
- Cost effectiveness
- Duplication
- Keep people in the community
- Quality of education
- Access to care
- Job market and college opportunity
- Quality of life

BARRIERS/OBSTACLES:

- Does change create better access??
- Baseline data -- improvements
- Faculty support/faculty development
- Direct reimbursement
- Rivalry territorial
- Funding formulae
- Public skepticism - value of higher degree
- Cooperation with dental education
- State dental association pressure
- Alumni support resources to establish
- Public versus private
- Philosophy and policies
- Mission of schools
- Administration view of dental hygiene position
- Cost of hygiene education
- Lack of having our own body of knowledge
- Defined as part of dentistry - differentiation

Lack of dental hygiene research
Transfer of credit commonality

TENTATIVE OUTCOMES:

Sharing resources
Hold meetings for schools not here at this meeting to learn about
alliances and articulation
Creating new positions
Talking to nursing homes, handicapped institutions, etc.
Topic for agenda at whatever meetings
East transfer of credits - Articulation curriculum
Upper and lower division
Cooperative curriculum development
Increased access to care
Funding - identify grant sources - private and federal
Establish alliances with government agencies, higher education
Establish stronger political alliances
Viable profession

SMALL GROUP SESSION I
ORANGE RECTANGLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

1. Power
2. Sharing knowledge
3. Idea exchange
4. Sharing resources
 - a. faculty
 - b. money
5. Discussing concerns
6. Common goals
7. Informing uniformed (colleagues)
8. Build trust factor
9. Build support network
10. Teaching career growth
11. Interdisciplinary networking
12. Eliminate duplication
13. Risk-taking is easier
14. Public relations
15. Intra and inter system continuity
16. Networking with social, political, professional agencies
17. Visibility
18. Greater rapport with the practitioner
20. Marketing tool
21. Recruitment of students and faculty

BARRIERS/OBSTACLES

1. Financial resources
2. Geographic location
3. Time
4. Lack of administrative support
5. Jealousy
6. Territorialism
7. Unwillingness to change
8. Legalities
9. Educational boards
10. Administrative policies and procedures
11. Tradition
12. Hidden agendas
13. Competition for students
14. Elitism

15. Differing educational philosophy
16. Lack of manpower
17. Reluctancy to share information
18. External influences
19. Decrease job security

TENTATIVE OUTCOMES:

1. Political clout
2. Increase in credibility
3. Increase in visibility
4. Facilitation formation of national alliances
5. Collaboration for grant money
6. Broadened base of support
7. Sharing/collaboration
8. Recruitment higher quality of students and education
9. Facilities future alliance
10. Greater achievement of program goals and philosophies
11. Developing external sites -- student outreach
12. Alternate delivery systems (ie., telecommunications)
13. Professional development
14. Autonomy/self-governance
15. Better health care providers/educators
16. Better transferability
17. Positive influence on accreditation
18. Peer review
19. Flexibility
20. Greater educational security
21. Greater trust
22. Outreach among educators
23. Continuity
24. Meeting regional needs
25. Long range planning

**SMALL GROUP SESSION I
GREEN SQUARE WITH RED CIRCLE
Thursday, March 5, 1987**

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

Shared resources - course content, faculty
Shared student pool and recruitment tool
Increased student satisfaction
Increased career options for students
Retain students longer in the educational institution
More educated, mature, well-rounded students/graduates
Improve program stability - students, finances
Save state monies, thus available for other programs
Faculty support systems
Help implement change, all programs work towards common goal
Collaborative teaching
Standardize curricula - within courses and across curriculum
Link for other professionals to enter dental hygiene

BARRIERS/OBSTACLES:

Non-standardized curricula
University/institutional reluctance
University/institutional degree granting requirements
Cost - faculty time, energy, etc.
Distance - location - geographics
Tuition cost differences between institutions
Recruitment - limit- different student to recruit to dental hygiene
Increased cost to institution/program
Lack of employment opportunities; need/demand
Salary differential
State practice acts
Funding - mandated
Organized dentistry
Politics -- a. institutional
 b. dental
Territorialism, turfdom - faculty, etc.
Student access to profession
Who's granting degree and what degree - dental hygiene other
Our (dental hygiene) own understanding
Definitions
Misunderstanding - need for communication within and beyond the
 profession
Cross coordination of courses
Accreditation -- meeting "their" standards

SMALL GROUP SESSION I
YELLOW DOT
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

1. Better applicant pool - quantity and quality
2. Early recruitment from high school - collaboration
3. Opportunities for expanded educational options
4. Increased respect in academic community
5. Increased cooperation and decreased competition
6. Increased interstate cooperation
7. Better knowledge of prerequisite preparation of all dental hygiene students
8. Greater longevity in the profession
9. Increased opportunities for employment in alternative settings
10. Achievement of bachelor's degree entry level
11. Better prepared for independent practice and alternative settings
12. Programs of inservice for collaborating faculties in order to enhance teaching of needed skills (ie., change agents, decision making, liberal thinking, etc.)
13. Mechanism for promoting dental hygiene as a profession

BARRIERS/OBSTACLES

1. Competition for students
2. Geographic isolation
3. Faculty attitudes and credentials
4. Difference in cost factors in university versus community college
5. Differences in institutional philosophy and mission
6. Pretension that all dental hygiene programs are equal/the same
7. No data to support need for advanced degrees (lack of employer demand data)
8. Faculty workload and burnout
9. Lack of public knowledge about dental hygiene
10. Dental associations
11. State Boards
12. Legislation

TENTATIVE OUTCOMES:

1. Establish mechanisms for communication on a regular basis
2. Cooperate for pooling resources in recruitment and sharing of applicants
3. Increase knowledge of public and raise awareness about dental

hygienists

4. Define mechanisms for coalitions with dentist who support dental hygiene
5. Sharing legislative activity
6. Delete "2 year/4 year" program terminology from vocabulary and substitute with name of degree awarded ("associate/baccalaureate degree program")
7. Provide specific details regarding setting up articulation agreements and obtaining resources available for this purpose
8. Develop list of bibliographic references and consultants relevant to existing articulations.

SMALL GROUP SESSION I
YELLOW RECTANGLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

Cost

Sharing resources -- a. Physical (library, space, facilities, research facilities
b. Human (faculty)

Quality education

Legislative power

Recruitment

Provides mobility for students

Better (quality) and expanded service to public

Increasing access to underserved populations

Increased visibility of profession to public

Increased communication

BARRIERS/OBSTACLES:

Fear of loss of autonomy

Lack of consensus re: dental hygiene practice/variability in practice acts and education

Administrative barriers/resistance/lack of support

Cost a. (for students)

b. (for institution - loss of tuition income)

Cultural differences

Dentists' attitudes

Lack of understanding from faculty (liberal arts and dental)

Local economy

Lack of justification for employment opportunities

Scope of practice (clinical or practical)

TENTATIVE OUTCOMES:

1. Increase communication resulting in increased participation in planning process and increased dissemination of accurate information
2. Research obtaining funding from state, federal agencies, private foundations, ADHA to develop a database and rationale to justify amount of education.
3. Identifying and market consumer's needs as it relates to dental hygiene services
4. Research costs of alliances and articulation (cost - benefit to student, institution)

SMALL GROUP SESSION I
RED SQUARE
Thursday, March 5, 1987

OUTCOME:

To form alliances in our area to begin to establish an educational system that prepares dental hygienists to perform future roles.

BENEFITS:

Recruitment
Create new opportunities
Provide a mechanism to communicate with other programs
Share resources
Reduce intensity of programs
Increased power base
Standardize dental hygiene practice
Increase mobility
Cooperation rather than competition
Technological advances

BARRIERS/OBSTACLES:

Getting past renovation to innovation
Technical education in community college credit
No definitive role delineation
State funding mechanisms
Accreditation standards
Geography
Rigid mind-set regarding curriculum
Non-transferrability of credit
Cost to students
Lack of perceived need
Turf protection
Administrative support lacking
Funding
Time for faculty to meet (interdisciplinary)
Lack of patience in obtaining goals
Lack of agreement on course content and degree of difficulty

TENTATIVE OUTCOMES:

Understanding and respect for each others' programs
Growth and development of faculty and profession
Stronger programs
Give up turf protection
Better able to meet the needs of the students
Serve public better
Continuing education expanded and more availability
Increase efficiency of operation

Cost containment
Development of areas of expertise
Increased knowledge base
Increased access to facilities
Practitioner
Practitioner encouraged to increase knowledge
Educate other professionals regarding oral health
Faculty agreements - inter-institutional

SMALL GROUP SESSION I
BLUE RECTANGLE
Thursday, March 5, 1987

OUTCOME: To form alliances in our area to begin to establish an educational system that prepared dental hygienists to perform future roles.

BENEFITS:

1. Free student mobility
2. Encourage continuing education exchanges
3. Increase exchange student educators and practitioners to make education more relevant.
4. Sharing resources (ie., curriculum, libraries, learning resources, faculty, students)
5. Trouble shooting, pitfalls - sharing
6. Collaborative research between educator/institution and practitioners and employer settings
7. Networking - overcomes isolation. Create coalition for power bases
8. Increase education about dental hygiene
9. Increase recruitment
10. Interdisciplinary educational exchanges.
11. Decrease educational costs - eliminate duplication
12. Increase educational opportunities (satellite clinics, extramural opportunities)
13. Increase employment opportunities for alternate practice settings (ie. employer wellness centers)
14. Increase demand for dental hygiene services
15. Standardized board exams - reciprocity
16. Tuition waivers
17. Interdisciplinary multiprofessional training in increased career mobility and better utilization of health manpower.
18. Extend dental hygiene to other health care facilities.

BARRIERS/OBSTACLES:

1. Course equivalent
2. Financial (start-up costs and development)
3. Manpower (time and energy)
4. Fear of change
5. Curriculum that lacks flexibility - rigidity
6. Turfdom
7. Knowing how to begin (who, what, where)
8. Geographic isolation
9. Cost of technology
10. Lack of information on need
11. Attitudes (faculty, administration)

12. Legal restrictions (state dental acts)
13. Transfer policies
14. Joint appointments (upgrading, employment benefits, tenure, academic calendars, salary)
15. Educational politics
16. College Districts
17. Upgrading of other auxiliary
18. Accreditation process
19. Dentists
20. Special interest groups in opposition
21. Job threat to alumni
22. Communication with alumni (one way)
23. Alumni and practitioner satisfied with status quo - low return on investment
24. Lack of broader knowledge base
25. Faculty qualifications for education of new roles
26. Applicant pool - qualified students
27. Loss of well educated dental hygienists to other other professions - burnout, etc.
28. No future in profession - attractiveness of profession
29. Restrictive practice
30. Terminal career

TENTATIVE OUTCOMES:

COURSE EQUIVALENCY:

- Identify course content to determine equivalency.
- Assess own attitudes within institutions (elitism).
- Instructor exchanges which lead to change of courses, leading to acceptance. Establish level of competency (testing, credit, challenge exam).
- Transfer policies.
- State mandate institutions establish equivalency (involve educators and consumers to encourage state to do this).
- Form coalitions between institutions (Administrators, educators).
- Identify person/people in power positions to accomplish this within institutions.
- Include power people in decisions and developing plans.
- Gain respect of those with whom you are working (humble self).
- Identify others who have already questioned the process.

FINANCIAL - START-UP COST AND DEVELOPMENT

- Write grant proposal - regional involvement.
- Check state statutes to see if support articulation.
- Check with Department of Higher Education to see if can provide manpower, writing, financial support.
- Check foundations and professional organizations (Kellogg, Carnegie, ADHA).
- Release time for faculty (experienced faculty); faculty exchanges.
- Utilize continuing education income (kick-back, certain percent of income applied).

STATE DENTAL ACTS - LEGAL RESTRICTIONS - Alternate Practice Settings
not allowed

- Needs assessment to validate need for dental hygiene.
- Network with other states that have specific functions (utilize personnel and methods).
- Establish pilot projects for data collection (involve alumni and legislators).
- Exchange students between states.
- Create consumer awareness.
- Build political coalitions.
- Identify dental hygienists in power positions.

DENTISTS ATTITUDES AND PERCEPTIONS OF DENTAL HYGIENE PROFESSION AND
KNOWLEDGE OF PROFESSION

- Increase collegial attitudes
- Lobby uncommitted dentists and legislators.
- Identify power base and educate.
- Identify and involve supporting dentists.
- Establish consumer base for support (ie. People's Medical Society).
- Influence dental students (educate, network, lend our support).
- Recruit dental hygiene practitioners to influence and educate dentists.
- Show economic feasibility and advantages of changing practice settings.
- Establish alliances with consumers:
 - a. educate in private practice (patients)
 - b. identify consumer groups with political power to validate needs
 - c. community activities (ie. sealant programs, geriatric care, quality care)
- Establish liaison contacts to and with consumer groups (national, state and local.
- Create media exchange on representation of dental hygiene (ie., toothpaste ads).

SMALL GROUP SESSION II
Yellow Circle
Friday, March 6, 1987

Outcome: Establish mechanism for communication on a regular basis.

Evidence Criteria: What will we see and hear to measure our progress and success? Tasks will be complete.

Resources:

<u>Available</u>	<u>Need to get</u>
California Educator's Association Annual Meeting	Will invite Washington, Idaho, Arizona, Nevada, and Oregon Educators
Texas Educator's Association Annual Meeting	Will invite New Mexico and Oklahoma Educators
State Dental Hygiene Associations	Contact people to serve as liaison with State Educator's Association

If we achieve this outcome:

Potential gain/losses?
Improved communication, better student recruitment, better public awareness programs, shared legislative efforts, etc.

Negative impact on anyone/anything else?
None.

Is it worth it to pursue this outcome? Yes.

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Send list of names and addresses of participants of Workshop IV to all participants and educators.	Denise Bowen will request of ADHA	May 1987
Submit the following resolution to the 1987 ADHA HOD: Be it resolved that ADHA recommends each constituent establish a task force consisting of educators and practitioners to address articulation issues related to Workshop IV.	Mary Jane Winters will work through ADHA District IX	June 1987

SMALL GROUP SESSION II
Yellow Circle (continued)
Friday, March 6, 1987

<u>Action (continued)</u>	<u>By Whom</u>	<u>By When</u>
Attempt to get articulation issues on agendas of annual meetings of California DH Educators (with other states invited) and Texas DH Educators (with other states invited).	Donna Barnes (CA) and Pat Nunn (TX)	June 1987
Suggest that this issue be placed on agenda for 1987 Director's Conference and 1987 ADHA Annual Session	Denise Bowen	April 1987
Provide specific details regarding setting up articulation agreements and obtaining resources for this purpose (at DH Educator's Workshops and upon request).	All	April 1988

Outcome: Cooperate for pooling resources in recruitment and sharing of applicants.

Evidence Criteria: What will we see and hear to measure our progress and success? Tasks accomplished.

Resources:

<u>Available</u>	<u>Need to get</u>
Same as outcome #1	Same as outcome #1

If we achieve this outcome:

Potential gain/losses? Increased applicant pools for dental hygiene schools in the region, decreased competition for students.

Negative impact on anyone/anything else? A few students lost, but more students gained ultimately.

Is it worth it to pursue this outcome? Yes.

SMALL GROUP SESSION II
Yellow Circle (continued)
Friday, March 6, 1987

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Get student recruitment and sharing of students on agendas for annual educator's meetings (see outcome #1)	Donna Barnes (CA) Pat Nunn (TX)	June 1987
Have members of group who are educators make referrals to neighboring schools when extra applicants are available.	Denise Bowen Karen Demetre Tricia Moore Glenna Taylor Pat Nunn Donna Barnes Dolores Malvitz Susan Clifford Martha Fales	Ongoing
Suggest that ADHA Subcommittee on Recruitment establish guidelines for effective recruitment, and develop recruitment materials that are consistent with the 6 roles identified for dental hygienists, and select appropriate terminology for describing the field.	Denise Bowen	July 1987
Delete "2 year/4 year program" terminology from vocabulary and substitute name of degree awarded (Associate/Baccalaureate degree program)	All	Immediately

Outcome: Increase in knowledge of public awareness about dental hygienists.

Share legislative activities related to dental hygiene in the Western Region.

Evidence Criteria: What will we see and hear to measure our progress and success? Tasks will be completed.

SMALL GROUP SESSION II
Yellow Circle (continued)
Friday, March 6, 1987

Resources:

<u>Available</u>	<u>Need to get</u>
Annual Educator's Meetings (established under outcome #1)	Invitations and agenda identified in outcome #1
Western Regional Newsletter for this small group	Newsletter established as outlined in outcome #1

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
More active Public Relations campaign (for increasing awareness about dental hygiene) including school and consti- tuent involvement during National Dental Hygiene Week and Children's Dental Health Month.	All Constituent Presidents will share ideas and programs (to be discussed at state educators/practi- tioners meetings)	Feb. 1988
Exchange legislative activities and public relations activities (ideas, materials, etc.) in a Regional news- letter.	Dolores Malvitz and Martha Fales	June 1987
Urge all hygienists and students to talk about the profession to patients (display licenses & plaques, business cards, etc.) and consumers.	Tricia Moore Glenna Taylor will submit ideas for newsletter	May 1987
Student Associations in region will submit a resolution to ADHA HOD for SADHA within a given state to work together toward above goals.	Pat Nunn and Karen Demetre will work with Texas and Washington SADHAs	June 1987

Outcome: Develop a list of bibliographic references and
consultants relevant to existing articulation/educational
alliances.

Evidence Criteria: What will we see and hear to measure our progress
and success? Tasks accomplished.

SMALL GROUP SESSION II
Yellow Circle (continued)
Friday, March 6, 1987

Resources:

Available

ADHA and publication of Workshop IV proceedings.

Need to get

Committee/ADHA to agree to incorporate above into proceedings.

If we achieve this outcome:

Potential gain/losses? Information will assist all interested parties in building alliances.

Negative impact on anyone/anything else? None

Action Steps:

Action

By Whom

By When

Request that ADHA staff (or Workshop Planning Committee) publish a list of bibliographic references and consultants with the Workshop IV proceedings (or separately).

Denise Bowen April 1987

SMALL GROUP SESSION II
Yellow Rectangle
Friday, March 6, 1987

Outcome: Increase communication resulting in increased participation in the planning process and increased dissemination of accurate information.

Evidence Criteria: What will we see and hear to measure our progress and success? The following will serve as outcome criteria:

Formal regional faculty meetings
Articulation in place
Creative educational delivery
Baccalaureate programs initiating articulation process
Changes in state law

Resources:

<u>Available</u>	<u>Need to get</u>
ADHA BOT, staff	Dollars
Coalitions with other allied health groups & consumers	Informed consensus & support
Curriculum grant monies	Political closet?
Institutional support programs	Members

Is it worth it to pursue this outcome? Yes.

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Dissemination of information to the faculty, D.H. organizations and practitioners.	This action will be coordinated by the following individuals in each state throughout the year: NJ--Ann Goodwin CT--Jocelyn Romer NY--Kathryn Sielski PA--Carolyn Hasbourt WV--Patricia Jones MA--Kathy Mellor	
Initiate formal faculty meetings with D.H. faculty, liberal arts and allied health.	Each participant (except Dona Wayman & Olga Ibsen) represented a different program so each will initiate this during the year.	

Contact and establish rapport with Admissions in each program represented.

SMALL GROUP SESSION II
Orange Rectangle
Friday, March 6, 1987

Outcome: Sharing/collaboration between regional dental hygienists.

Evidence Criteria: What will we see and hear to measure our progress and success?

1. Documented contacts between/among practitioners & educators.
2. Develop information list (gained & passed on between individuals).
3. Documented evidence of feedback.

Resources:

<u>Available</u>	<u>Need to get</u>
Xerox machine	Administrative support
Postage	Time
Newsletters	Manpower
Bulletins	ADHA
Phone call-long distance	Money
Faculty/Practitioners	Energy
Mailing lists	
ADHA	
AV Materials	

If we achieve this outcome:

Potential gain/losses?

Gain: Broader support base, visibility, access to more information, professional membership.

Losses: Stress, loss of support, loss of financial support.

Negative impact on anyone/anything else? None.

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
1. Contact alumni	Recie Pennell	June 1987
2. Discuss with faculty & administrators	Recie Pennell	June 1987
3. Share results of study	Sharon Graydon	June 1987
4. Survey of dentists in Michigan	Mary Ann Hashimi	July 1987
5. Sharing of curricula/course description	Linda Leshner	July 1987
6. Survey of dental hygienists by educators in Michigan (deals with membership & attendance).	Bev McDonald	July 1987

SMALL GROUP SESSION II
Orange Rectangle (continued)
Friday, March 6, 1987

Outcome: Sharing recruitment ideas.

Evidence Criteria: What will we see and hear to measure our progress and success? Everyone receiving information from group members.

Resources Available:

ADHA
Individual institutions

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Send materials (Kurt will follow-up if he doesn't receive materials by July.)	Kurt Truax	July 1, 1987

SMALL GROUP SESSION II
Red Rectangle
Friday, March 6, 1987

Outcome: Identify a barrier to an integrated entry level
baccalaureate degree for dental hygienists and work toward
breaking down this barrier.

Evidence Criteria: What will we see and hear to measure our progress
and success?

1. Alliances forming between institutions.
2. Have a log (file) of the steps involved.

Resources Available:

Manpower

If we achieve this outcome:

Potential gain/losses? Breaking down some barriers, obtaining
information

Negative impact on anyone/anything else? Frustration. Barriers
that are difficult to overcome. Don't try to take actions without
a clear objective(s).

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
1. Each person will contact one institution or organized group to identify a barrier & work to break down this barrier.	Each person	March 1, 1988
2. Document steps taken to break down these barriers.	Each person	March 1, 1988
3. Inform ADHA of progress. (Cheryl or Gloria) <u>address</u>	Each person	March 1, 1988

SMALL GROUP SESSION II
Red Rectangle (continued)
Friday, March 6, 1987

Outcome: Identification of the post-certificate dental hygiene programs in the Midwest, and the sharing of this information.

Evidence Criteria: What will we see and hear to measure our progress and success?

1. We will become better informed advisors for students.
2. Resources will be readily available in each school (resource library).
3. ADHA informed of progress.

Resources Available:

AADS listing of programs
ADHA listing of programs
Accreditation status/info

If we achieve this outcome:

Potential gain/losses?

Increased knowledge.
Have more RDHs with BA or BS in Dental Hygiene.
Recruitment increased.

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
1. Compile a list of post-certificate programs & prepare a fact sheet (contact person, basic program, prerequisites) from these schools & send this fact sheet to Dental Hygiene programs in the Midwest states. Michigan-11, Minnesota-4, Wisconsin-6, Ohio-9, Nebraska-2, Iowa-3, Illinois-8	Wendy Kerschbaum U of Michigan	Aug. 31, 1988
2. One person from each state will follow-up with a personal contact for non-represented schools at this conference. (*Person not present in group.)	NB-Gail Hlava MN-Kathy Newell* IA-Kay Mescher OH-Trudy Palmateer IL-Shirley Beaver* MI-Wendy Kerschbaum	Dec. 31, 1988
3. Inform ADHA of progress.	Everyone	Continuous effort.

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SMALL GROUP SESSION II
Green Rectangle with Red Dot
Friday, March 6, 1987

Outcome: Regional Meetings to assess curriculum and articulation possibilities.

Evidence Criteria: What will we see and hear to measure our progress and success?

1. Attend meetings.
2. Keep documentation.
3. Report progress to ADHA.

Resources:

<u>Available</u>	<u>Need to get</u>
1. People support groups' names & addresses	1. Clerical support, supplies, phone, mail
2. Proceedings of this workshop	2. Person to be in charge
3. Existing organized educators (MI & OH have annual meetings of dental hygiene educators)	3. Support & information from institutions involved
4. District ADHA meetings	4. Meeting place & date

Action Steps:

<u>Action</u>	<u>By Whom</u>
Set a place to meet.	Deb
Agenda item at MDHA to disseminate info. Ohio educators conference	Chris
Establish Illinois Educators Committee	Mary, Susan, & Shirley
Share information at constituent level.	Judy

Outcome: Promote and gain support for the Baccalaureate entry level concept.

Evidence Criteria: What will we see and hear to measure our progress and success?

RDH gaining/obtaining Baccalaureate degree
Practitioner ask for the Baccalaureate degree

SMALL GROUP SESSION II
Green Rectangle with Red Dot (continued)
Friday, March 6, 1987

Action Steps:

<u>Action</u>	<u>By Whom</u>
Contact Practitioners of state to inform them of the resolution of baccalaureate degree entry level.	
Call Iowa president. Nebraska	Judy Crystal
Ohio	Chris
Speak to her employer about ADHA designing a flyer to be sent to all licensed dental hygienists.	Ellen
Produce one copy to be sent to each state president to then be sent to all.	

SMALL GROUP SESSION II
Green Circle
Friday, March 6, 1987

Outcome: Regional faculty forum at 1988 regional student-faculty meeting.

Evidence Criteria: What will we see and hear to measure our progress and success?

Diane Bassage to contact Karen Shattuck at 1987 District Student Meeting.

Three or four program directors who are in close geographic proximity of site of 1988 District Student Meeting to form steering committee for the regional faculty forum.

Resources:

Available

Karen Shattuck, Chair of Hudson Valley Program

Ilene Biller-Karlsson, resource person for faculty development topics.

Marcia Brand, resource person for documentation of positions in region that require baccalaureate degree in dental hygiene.

Jackie Singer, resource person for alternate dental hygiene positions (nontraditional) in region.

A listing of benefits and barriers for alliances as identified by the Green Circle Group at this conference.

Need to get

Accessible location for the forum

Steering Committee

Funding? May not be a significant factor if Faculty Forum is held concurrently with Regional Student Meeting.

If we achieve this outcome:

Potential gains/losses? More communication among educators. Documentation of dental hygiene positions in region that require baccalaureate degrees, and documentation of alternate role positions in region. Faculty development.

Negative impact on anyone/anything else? Those programs that will not attend and/or participate in the Faculty Forum.

Is it worth it to pursue this outcome? Yes.

SMALL GROUP SESSION II
Green Circle (continued)
Friday, March 6, 1987

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Introduce this Outcome at 1987 District Student Conference	Dianne Bassage	3-4 weeks
Explore appropriate site for 1988 Faculty Forum. Possibly in Boston area.	Linda Hanlon	
Form Steering Committee		
Use identified benefits and barriers as topics for forum--a panel presentation	Steering Committee	
Identify panel presentors	(See Available Resources)	

Outcome: National organized policy forum for dental hygiene educators.

Evidence Criteria: What will we see and hear to measure our progress and success?

Development, distribution, and analysis of survey to determine what educators feel is currently lacking in policy development related to dental hygiene education.

Strengthened ADHA alliances with dental hygiene educators.

Formation of ADHA Ad-Hoc Subcommittee to study feasibility of formal dental hygiene educators policy forum.

Resources:

<u>Available</u>	<u>Need to get</u>
Existing AADS Section on Dental Hygiene. Not appropriate body for policy making for dental hygiene. However, an appropriate body as research forum and some faculty development.	Need more autonomous group for dental hygiene education policy development. Need group separate from AADS.

SMALL GROUP SESSION II
Green Circle (continued)
Friday, March 6, 1987

If we achieve this outcome:

Potential gains/losses? More autonomy in development of dental hygiene education.

Negative impact on anyone/anything else? AADS Section on Dental Hygiene and relationship with AADS.

Is it worth it to pursue this outcome? Yes.

SMALL GROUP SESSION II
Green Rectangle
Friday, March 6, 1987

Outcome: Faculty workshop

Evidence Criteria: What will we see and hear to measure our progress and success?

1. Scheduled workshop--time, location, topics
2. Scheduled speakers
3. Printed materials/handout for participants
4. Promotion of workshop

Resources:

<u>Available</u>	<u>Need to get</u>
1. ADHA	1. Funding/resources
2. Depts. of Education	2. Coordinator/Committee
3. Individuals of this group	3. Faculty
4. Companies (Dental Products, etc., funding)	4. Speakers
5. Other professional (disciplines, allied health, educators, etc.)	5. Needs assessment data
	6. Information on each program
	7. Survey

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
1. Establish Coordinator/Committee	Group	Today
Coordinator: Joe Lynch, KY		
Committee: Linda Amos, NC		
Constance Lee, VA		
Caren Barnes, AL		
Linda Edwards, FL		
Patsy Littlejohn, TN		
Mary Ackerly, MS		
Cyndi Brown, AR		

SMALL GROUP SESSION II
Green Rectangle (continued)
Friday, March 6, 1987

<u>Action (continued)</u>	<u>By Whom</u>	<u>By When</u>
2. Communication (letter & survey) to programs to introduce idea of workshop --mail to every faculty member in southern region.	Cyndi Ann Linda Linda	During AADS mtg. draft will be developed; Linda will mail formal letter.
3. Obtain names of faculty from ADHA.	Linda	Shortly (2 wks.) after AADS mtg.
4. Develop Plan B in case workshop won't work--have alliance workshop in each state vs. region. Inform group members if workshop needs to be state-wide vs. regional.	Joe will inform	Six months.

SMALL GROUP SESSION II
Red Circle
Friday, March 6, 1987

Outcome: Educate components, faculty, students, and others about workshop (articulation).

Evidence Criteria: What will we see and hear to measure our progress and success?

1. Article in Component or state newsletter.
2. Agenda item on state board meeting, i.e. Constituent Board.
3. Agenda on faculty meetings.
4. Presentations at state meetings.

Resources:

<u>Available</u>	<u>Need to get</u>
1. Each other	1. Proceedings from current workshop
2. Materials gathered at workshop	2. Needs survey to assess articulation needs
3. ADHA	3. ADHA News release components & hygiene programs
4. SADHA	
5. Proceedings from previous workshops	

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
Meet with other d.h. programs in state	Missouri	June 1987
Meet with officers	Michigan	Oct. 1987
Meet with d.h. faculty	Michigan	May 1987
D.H. educator's meeting	Ohio	April 1987
Futures workshop at Annual Session	Wisconsin	May 1987
BOT	Madison, WI	March 1987
Directors' programs meeting	Illinois	March 1988
Report at next Constituent Board Meeting	All States	Next appropriate mtg.

SMALL GROUP SESSION II
Red Circle (continued)
Friday, March 6, 1987

<u>Action (continued)</u>	<u>By Whom</u>	<u>By When</u>
*Obtain ADHA news release		March 1987
*Article in ADHA Journal with synopsis & all D.H. publications		Aug. 1987
*Recommend article in newsletter to all licensed hygienists by next constituent meeting		
*Request space on faculty mtg. agenda to report on workshop	All Educators	April 1987
*Recommend development of needs assessment by ADHA for articulation		
Talk to SADHA advisors	All	March 1987

*These items need to be edited due to group's persistent opinion that we need resources available through ADHA.

SMALL GROUP SESSION II
Blue Circle
Friday, March 6, 1987

Outcome: Establish communication with as many groups as possible.

Evidence Criteria: What will we see and hear to measure our progress and success?

1. Contact will be made.
2. Information will be published in state and Component newsletters.

Resources:

<u>Available</u>	<u>Need to get</u>
People in the group	Support of other faculty, students to initiate further contacts

If we achieve this outcome:

Potential gain/losses?

Steps toward professionalization and establishing baccalaureate as entry

Action Steps:

<u>Action</u>	<u>By Whom</u>
Forming alliances with: D.H. Educators & State Associations	Anita Herzog, Karen Wells, Cheryl Cameron, Janie Nable, Myrna Kalman
Introduce resolution on state level to affirm B.S. as entry level	Jan Shurts, Peg Ryan
Publish information on this workshop & direction of d.h. in state & component newsletters/journals	Barbara Nelson, Jan Shurts, Myrna Kalman, Anita Herzog
Place articulation on the agenda of state meetings	Jan Shurts
Speak to students and alumni	Barbara Nelson, Karen Wells, Jan Shurts, Janie Nable
Contact other schools & allied health groups that have articulation potential	Barbara Nelson, Jan Shurts, Myrna Kalman, Anita Herzog, Mary Lou Abbott

SMALL GROUP SESSION II
Blue Circle (continued)
Friday, March 6, 1987

<u>Action (continued)</u>	<u>By Whom</u>	<u>By When</u>
Contact each of the DH programs in Oregon to share results of this mtg.	Evelyn Hobbs	
Share information with other faculty administrators & advisory committee registrars	Evelyn Hobbs	
Share info with WA State D.H. directors Cheryl Cameron		
Contact State/Regional Boards governing higher education		
Written report to CAL BOT & House of Delegates mtg.	Myrna Kalman	April 1987
Meet with faculty & determine curriculum directions for the future	Peg Ryan	

SMALL GROUP SESSION II
Blue Rectangle
Friday, March 6, 1987

Outcome: Dental Hygiene education/courses accepted for upper division credit.

Evidence Criteria: What will we see and hear to measure our progress and success?

Upper division credit granted
Acceptance of DH students at 4th year without backtracking.
Curriculums shared from institutions to evaluate minimum competencies
Evidence of student mobility
Development of competency exams
Acceptance by course description, accreditation, and licensure
Acceptance of expanded function by regulation agencies

Resources:

Available

Need to get

Individuals aware of higher education policies (i.e. Academic Affairs, Administration, Registrars)

Curriculum evaluations (state, regional)

ADHA Curriculum Consultants

Computer Programming and Access

Other institutions with articulation agreements (Idaho State Univ., Rose State College)

Funds for individuals and institutions to meet

Involvement and Support of Faculty

Identify coordinator for activities

SMALL GROUP SESSION II
Blue Rectangle (continued)
Friday, March 6, 1987

Action Steps:

<u>Action</u>	<u>By Whom</u>	<u>By When</u>
District Educator mtgs. including practitioners	ADHA & Districts	
Resolution to ADHA for #1	Sharon Golightly	April 1987
Contact each trustee, for the districts represented in this group, to support the resolution		
District 9 Jan Shurtz	Susan Marcus	
10 Debbie McFall	Donna Stach	
12 Betty Sherman	Sharon Golightly	
13 Jackie Clark	Anna Pattison	
Regional D.H. Educators mtg. initiated in NM to discuss clinical skills & minimum competencies. Report of progress.	Jan Warren	Oct. 1988
Contact other institution to assess articulation possibilities (own state or adjoining state)	Each member of group	March 1988
ADHA contact person to disseminate existing articulation agreements via the new <u>Access</u> publication	ADHA	
Survey student members regarding their interests, goals, options. Curriculum content in articulation agreements	ADHA	

WORKSHOP EVALUATION

To determine the satisfaction level with specific Articulation: Alliances for the Future workshop aspects, participants were requested to provide comments. Based on a Likert-type scale ranging from one to six (one being the measure of highest magnitude), participants were asked to rate their level of satisfaction regarding:

- Workshop goal attainment
- Poster session innovativeness
- Speakers subject matter effectiveness
- Participant interaction ability in small group sessions
- Group leaders' facilitative abilities
- Time allocation for general and small group session
- Adequacy of workshop accommodations.

In addition to the 18-question evaluation, participants were requested to list at least three strengths and three limitations of the workshop. The evaluation also requested general comments.

All workshop participants, excluding the Planning Committee, received an evaluation questionnaire. Of the 138 instruments distributed, 53 were returned, representing a response rate of 38%. Due to the limited response rate, interpretation should be conservative in nature.

The mean for the 15 questions requiring a numerical rating was 2.0. These data indicate that the respondents were generally satisfied with the workshop.

In identifying the workshop strengths, participants indicated that the workshop:

- provided a forum for participants to interact and plan for the future
- addressed issues of regional and national importance
- dealt with timely issues
- provided for productive outcomes.

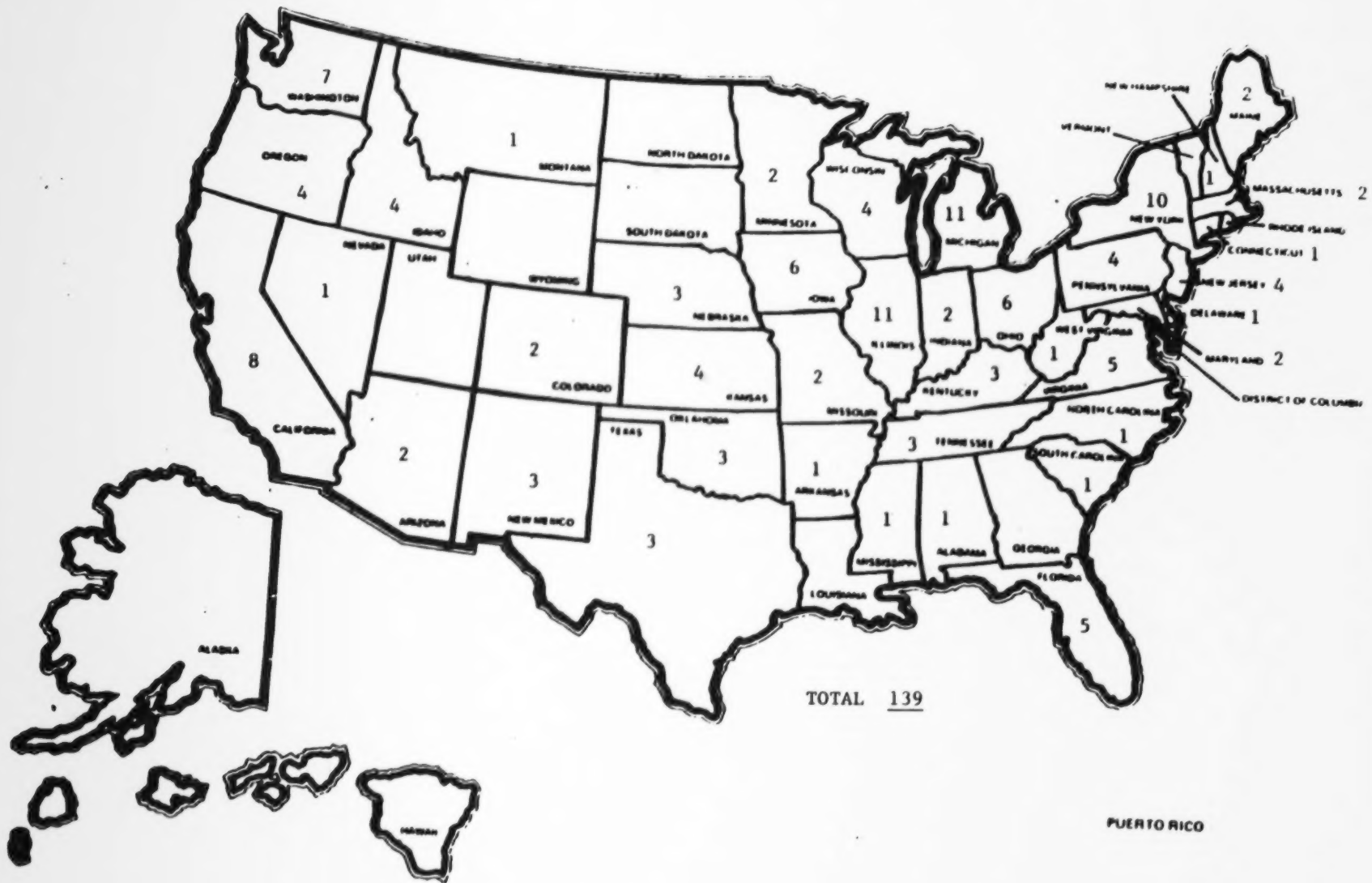
Also cited as a major strength was the workshop planning and organization.

Workshop limitations expressed by less than 5% of the participants included:

- time for participant/speaker interaction
- representation from diversified dental hygiene communities of interest
- time for small group interaction.

General comments made by participants indicated that there is a continuing need to meet to address articulation and professionalization issues. Sharing ideas and working together to meet the needs of the public and the profession was deemed critical.

NATIONAL REPRESENTATION



TOTAL 139

PUERTO RICO

140

141

131

Workshop Participants

<u>Registrant</u>	<u>ST</u>	<u>Registrant</u>	<u>ST</u>
ABBOTT*MARY L	MT	DINIUS*ANN	VA
AKERLY*MARY	MS	EDWARDS*LINDA M	FL
AMOS*LUNDEE	NC	EMPEY*MARGE	OR
BARNES*CAREN M	AL	FALES*DR. MARTHA	WA
BARNES*DONNA P	CA	FERN*CRYSTAL	NE
BASSAGE*DIANE M DEROOS	MD	FORREST*JANE L	NJ
BEAVER*SHIRLEY M	IL	FRASER*LYNNETTE S LYNN	OH
BENKERT*KIMBERLY K	IL	FRIEL*KATHERN R	DE
BIETHMAN*MARGARET CERRA	KS	FRITZ*SHELLY	NM
BILLER-KARLSSON*ILENE R	PA	GARVIN*CYNTHIA M	WA
BOWEN*DENISE	ID	GASTON*MARY ALICE	TN
BRAND*MARCIA K	PA	GILL*JOAN CAROL	OH
BROWN*CYNTHIA A	AR	GOLIGHTLY*SHARON	WA
BUTLER*TERESA	KY	GOODWIN*ANN M	NY
CAMERON*CHERYL ANN	WA	GRAYDEN*SHARON K	MN
CARTER*DEBORAH M.	MI	GURENLIAN*JOANN RIGOLIZZO	NJ
CLIFFORD*SUSAN B	CA	HANLON*LINDA L	MA
COATS*LINDA LOWE	WA	HARBOURT*CAROLYN	NJ
COOPER*NANCY P	NM	HARTJE*JUDITH	WA
CUNNINGHAM*ANITA CARTER	NY	HARTNETT*CAROLYN J	NH
DAILEY*BETH A	WI	HASHIMI*MARY ANN	MI
DARBY*MICHELE L	VA	HEISCHMIDT*CYNTHIA E	IL
DAVIDSON*JUDITH	ME	HERZOG*ANITA	ID
DAVIS*BRENTA	TN	HLAVA*GWEN L	NE
DECK*SALLY ANN	MI	HOBBS*EVELYN	OR
DEMETRE*KAREN LEE	WA	HOLLOWELL*THERESA L	MI

Workshop Participants

<u>Registrant</u>	<u>ST</u>
HOLT*MARIANNE P	IL
HOOD*EMILY H	FL
HUNTLEY*DIANE E	KS
HUTCHERSON*ANNE B	VA
IBSEN*OLGA A C	NY
JAMES*SELENA	NY
JANSSEN*JULIE A	IL
JANUSZ*SUE	IL
JENSEN*CATHERINE L	IL
JENSEN*STEVE	IL
JONES*PATRICIA A	WV
KALMAN*MYRNA	CA
KEE*CONSTANCE LADY	VA
KERSCHBAUM*WENDY ELLEN	MI
KNIGHT*MARY M.	FL
KRAEMER*LINDA G	PA
LEE*JOLEEN	ME
LEGGETT*SANDRA K	IA
LEMON*SHERRY L	OR
LESHER*LINDA SUE	OH
LITTLEJOHN*PATRICIA	TN
LUGENBEEL*DR. ARCH	SC
LYNCH*DR. JOSEPH R	KY
MAC DONALD*JEAN ANN	MI
MALONEY*KAREN	IL
MALVITZ*DOLORES M	OK

<u>Registrant</u>	<u>ST</u>
MARCUS*SUSAN B	OK
MC CLINTOCK*JOAN L.	PA
MC FALL*DEBI L	CO
MCDONALD*BEVERLY A	MI
MCKENNEY*NANCY R	WI
MEADOR*DR. RUBY F.	KY
MELLOR*KATHY J	MA
MESCHER*KAY	IA
METZGER*CHERYL TROY R	MO
MILLER*DEBORAH LOU	ID
MOORE*TRICIA	AZ
MUNGER*MAUREEN M	MI
NELSON*BARBARA	NV
NEWELL*KATHLEEN J	MN
NOBLE*JANIE SUE	TX
NUNN*PAT	TX
ODRICH*JOHANNA	NY
OSER*KAY E	IN
OVERMAN*PAMELA R	KS
PAARMANN*CARLENE S	ID
PALMATEER*TRUDY M	OH
PATTISON*ANNA	CA
PELTON*BETH L F	IA
PENNELL*RECIE	KS
PETERSON*RUTHANN	WI
PITZ*ELIZABETH	NY

Workshop Participants

<u>Registrant</u>	<u>ST</u>
PODRUCH-CONARD*LUCY	WI
POUPARD*JEAN	CA
ROBERTUS*RENEE	MO
ROGO*ELLEN J	NY
ROMAN*JOCELYNE D	CT
RYAN*MARGARET M	OR
SAUER*SUSAN L	IL
SCHMIDT*PAULINE	OH
SCOTT*WANDA A	MI
SHANNON*SHEA	CA
SHURTS*JANET KAY	OK
SIELSKI*KATHRYN ALM	NY
SIMMONS*CHRISTOPHER L	OH
SKELTON*JUDITH	FL
SLACH*NANCY A	IA
SLATTERY*LINDA F	MO
SMITH*JUDY O'BRIEN	IA
SMITH*ROBERTA	NY
STACH*DONNA J	CO
TAYLOR*GLENNA	NM
TOLLE*SUSAN L	VA
TRUAX*KURT H	AR
TURNER*SARAH A	IA
TUSSING*CONNIE EDSTROM	NE
WATKINS*MARJORIE	IL
WAYMAN*DONA ELANE	NY

<u>Registrant</u>	<u>ST</u>
WEISENBORN*LEE	FL
WELLS*KAREN VAN AUKEN	CA
WESTPHAL*CHERYL	NJ
WILSON*DEBRA S	CA
WILSON*JANET K	MI
WINTERS*MARY JANE	TX
ZARKOWSKI*PAMELA	MI

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